

Provider Training

Adult Day Health Care Facilities

September 11, 2007

## Index

1. Presentation slides
2. ADHC Standards for Payment
3. DHH Residential Care Rate Setting Manual
4. Facility Cost Report Form
5. Instructions for Cost Report Form
6. Correspondence from DHH
7. Census Information
8. Information from the Provider Reimbursement Manual (HIM-15)

## Agenda

- Introduction
- Overview of Cost Report Form
- Basic Cost Principles
- Attendance Records
- Wrap Up

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## Objectives for this Session

- Improve your understanding of the Medicaid Cost Report
- Increase your knowledge of cost principles
- Improve your understanding of attendance records requirements

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## Technical References

- Adult Day Health Care Standards for Payment (SFP)
- DHH Residential Care Rate Setting Manual
- Cost report form and instructions
- Correspondence from DHH
- Medicare Provider Reimbursement Manual (PRM or HIM-15)
  - [www.cms.hhs.gov](http://www.cms.hhs.gov)

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**General Information**

- Cost report should be prepared for facility and any home/central office
- Software for cost report can be downloaded free from [www.medimax.com](http://www.medimax.com)
- DHH Rate and Audit Review Website
  - <http://www.dhh.louisiana.gov/rar>
  - See sections titled:
    - Publications
    - Reports
    - Adult Day Health Care

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**General Information**

- Cost report should be filed on or before the last day of September
  - If weekend or holiday, due the next business day
- Extensions
  - Must be requested in writing
  - Only for unavoidable difficulties
  - Must include full statement of the cause
- File 2 copies of cost report and attachments

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**General Information**

- Required attachments to Filed Cost Reports
  - Working trial balance that identifies which cost report line item an account is included in
  - A depreciation schedule
    - If hospital based, the schedule must clearly show Hospital only, ADHC only and shared assets
  - An amortization schedule, if applicable
  - A schedule of adjustments and reclassification entries
  - A narrative description of purchased management services or a copy of the management services contract

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**General Information**

- Required attachments to Filed Cost Reports
  - If related party management services:
    - Home office cost report
    - Home office allocation schedule
      - Including a description of the allocation basis used
    - Copy of contract or narrative description of contract services
  - If hospital based:
    - Medicare worksheets A, A-6, A-7, A-8, A-8-1, B part I and B-1
    - Allocation worksheets

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**General Information**

- Use whole dollars
  - Only per diem amounts will not be rounded
- Cost report line item titles (descriptions) should not be written over
- “Miscellaneous” and “Other” line items require a detail or supplemental schedule to specify types of costs and amounts
- Include cost allocation schedule(s) for all allocated costs (central office, hospital, etc.)

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**General Information**

- Accrual basis of accounting is required
  - if not used during the year, the information must be converted to accrual basis for cost report purposes
- Cost report period must be July 1 – June 30
- All records must be kept for at least 5 years
- Complete all sections even if response is None, N/A, or \$0

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### Overview of Cost Report

- Pages 1-6 Administrative and Statistical
- Page 7 – Staffing Pattern
- Pages 8 & 9 – Balance Sheet
- Page 10 – Income Statement (Revenue)
- Pages 11-15 – Schedules of Costs

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### Overview of Cost Report

- Page 16 – Calculation of Costs Per Day by Category
- Page 17 – Direct Care Cost Settlement
- Pages 18 & 19 – Schedule of Adjustments
- Page 20 – Depreciation Schedule
- Page 21 – Certification Page

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### Pages 1-6

- Page 1 – Select one Type of Control only
- Page 2 – Licensed capacity should agree to the facility’s license at beginning & end of the cost report period
- Page 2 – Total client days available
  - should reflect any change in licensed capacity during the cost report period
  - should be based on the number of days the facility was open during the cost report period
- Page 2 – Report all days of attendance regardless of payment method or source

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### Pages 1-6

- Page 3 - Ownership Disclosure
  - Should include information regarding owners, relatives, and/or key personnel
  - For non-profit providers, this means listing officers/board of directors/key personnel and relatives who work for the facility (see HIM-15, Chapter 10)
  - Job descriptions and written documentation of time worked for the persons listed on page 3 are required as supporting documentation
  - All columns should be completed
- Page 3 – Lease information
  - Disclose all facility and vehicle leases
  - Disclose if lessor is a related party

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### Pages 1-6

- Page 4 – Related Party Transactions
  - All transactions with a related party should be disclosed on page 4
  - Related party transactions should be adjusted to allowable costs
    - See slides 34 and 35 for further details
- Page 6
  - Disclose other rates received

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### Page 7 Staffing Pattern

- Should report each position
  - Can have multiple persons filling one position
- Actual salary for the CR period should agree to/reconcile to salaries reported on Schedules A thru C
- Average hours per week should relate to salary reported
  - For example – an LPN who works full-time: hours per week would be 40

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**Pages 8, 9 & 10**

- Enter amounts per books at the end of the period
- Routine service income should be equal to days times per diem for each payor type which pays on a per diem basis
- Other revenue should be recorded at gross amount per general ledger
  - Offsets are recorded only on Schedules A thru D
  - All other income and grant income should be offset against the related expense on Schedules A thru D
- Specify type and amount of items included in Miscellaneous income
- Provide details of all grant income

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**Schedules A - D**

- Column (a) should agree to the general ledger for the cost report period
- Column (b) should be used to record cost report adjustments
- Column (c) should reflect only allowable costs

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**Schedules A - D**

- Attach supplemental schedules, as needed, to describe amounts reported as “miscellaneous” and “other”. The sum of the amounts associated with each description should equal the amount reported
- Any costs described as “miscellaneous”, “other”, “various” without further detailed explanation will be automatically disallowed.
- For facility cost reports, all central office expense should be reported on Schedule C, line 30. The provider should not report the central office expenses on any other line of the facility cost report.

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**Schedule A – Direct Care Costs**

- Salaries and related costs for:
  - RNs, LPNs, Aides, Social Services, Activities
  - Excludes Activity Director
- Contract employees for the same positions
- Drugs
- Medical supplies
- Medical waste disposal
- Allocated hospital direct care costs

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**Schedule B – Care Related Costs**

- Salaries and related costs for:
  - Supervisory staff (nursing, social services & activities)
  - Dietary staff
- Consultant Fees for:
  - Activities
  - Nursing
  - Pharmacy
  - Social Worker
  - Therapists
- Food & supplements
- Supplies for activities and social services (excluding dietary supplies)
- Allocated hospital care related costs

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**Schedule B (cont'd)**

- Consultants
  - Consultant section of Schedule B (line 6a-6e) and Schedule C (line 16) should include those parties with whom a care-related contractual relationship exists.
  - Should NOT include:
    - Routine medical care
    - Direct care services (i.e., contract employees)
    - Salaried personnel

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### Schedule C – Admin. and Operating

- All other salary and related costs
  - Administrator(s), Housekeeping, Laundry, Maintenance, Drivers, Other Admin, Owner
- Contract employees for same positions
- Consultant Dietician
- All other administrative, housekeeping, maintenance, laundry costs
- Dietary supplies
- Interest on non-capital and vehicles
- Management fees/Home office costs
- Non-emergency transportation
- Vehicle insurance expense

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### Schedule D – Property and Equipment

- Depreciation expense
- Amortization – capital related
- Interest – capital related
- Property taxes
- Property insurance
- Rent
  - Building
  - Furniture and Equipment
- Auto lease
- Allocated hospital capital costs

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### Schedule E – Cost Summary

- Column (a) - Allowable Costs from each Schedule A – D
- Column (b) – Total client days from page 2
- Column (c) – Calculated as column a/b

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**Schedule F – Direct Care Cost Settlement**

- Lines 1 and 2a – Calculation of Direct Care Floor
  - Medicaid days X Direct care rate component (per DHH rate letter)
  - Times 90%
  - For 2007, days must be split into two periods because of 2 rates during the period (see Tab 6)
  - Complete this page manually and insert into CR
- Line 2 – Calculation of Medicaid Direct Care Allowable Costs
  - Medicaid Days X Direct Care Costs/Day (from Schedule E)
- Line 3 – Amount Due to State

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**Schedule of Adjustments**

- Should include explanations of adjustments, not just line item descriptions
  - For example: Correct – To offset misc. income
  - Incorrect – Admin Misc expense
- Adjustment amounts must be carried to Schedules A – D
- Do not record adjustments to subtotal or total lines on Schedules A – D.
- Make sure adjustments are posted to Schedules A – D in the correct direction (i.e., as positive or negative adjustments)

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**Page 20 - Depreciation Schedule**

- Should report only allowable assets and related depr. expense and accumulated depr.
- Depreciation expense should agree to depreciation expense reported on Schedule D
- Asset useful lives must be in compliance with ranges in Medicaid regulations
  - DHH Residential Care Rate Setting Manual pages 3.5-23 & 3.5-24

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**Page 20 – Depreciation Schedule**

- Straight-line depreciation must be used
- Expenditures must be capitalized if cost is at least \$5,000 and the useful life is at least 2 years
- Detail depreciation listing must reflect individual assets with specific description of asset, not vendor name

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**Page 21 - Certification Page**

- Must be signed by authorized facility representative

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**Home Office Cost Report**

- Should be filed when shared or allocated costs are reported on the facility cost report.
- Use the same cost report form as the facility
- Should include only costs related to the management of the facilities/programs
- Detail allocation schedules should be attached to the home office cost report and attached to each facility cost report

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### Home Office Cost Report

- Allocation schedules should reflect total shared costs, allocation percentages used and method of allocation
- Allocation should be based on client days or total costs.
- Do not allocate the same costs twice
- Remove costs for unrelated businesses, such as rental business, etc. prior to allocating home office costs

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### Basic Cost Principles

- Allowable cost
  - Reasonable
    - Expectation is that the provider seeks to minimize costs
    - Costs do not exceed what a prudent and cost conscious buyer would pay
    - Related to client care
  - Necessary and Proper
    - costs to develop and maintain the operation of client care facility and activities
    - costs which are common and accepted occurrences in field
- Generally accepted accounting principles (GAAP) are required (i.e., accrual basis of accounting)
  - Information sources are general ledger/financial statements and census records

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### Basic Cost Principles

- Interest is allowable if it is:
  - necessary for the operation of the facility & reasonably related to client care
  - proper - reasonable rate
  - interest expense should be reduced by interest income
  - related party interest is limited to underlying interest cost to related party

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**Basic Cost Principles**

- **Related Party Transactions**
  - Can be related through common ownership or common control
    - Ownership
      - Significant ownership or equity interest
    - Control
      - Key officers/board members
  - Exception
    - Transaction has to meet 4 criteria
  - See Chapter 10 of the PRM

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**Basic Cost Principles**

- **Related party**
  - owner’s salary
    - See slides 37 and 38
  - Salaries of other related parties
    - Must meet the same standards as owner’s salary
  - rent/lease expense
    - Allowable to the extent of the underlying cost to the related party. Costs should be properly classified (i.e., depreciation should be reported on the depreciation line, interest on the interest line of the cost report, etc.

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**Basic Cost Principles**

- **Related party**
  - management fees
    - Related party management fees must be supported by a Medicaid cost report filed by the related party management company, accompanied by an appropriate allocation schedule. All related party management companies are subject to Medicaid audit.
  - interest
    - Related party interest is allowable to the extent of underlying interest expense incurred by the related party, and is subject to the rules regarding allowability of interest expense outlined previously.
  - other

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## Basic Cost Principles

- Owner's Compensation
- The Medicare Provider Reimbursement Manual (HIM-15), Chapter 9 addresses compensation of owners. The following briefly summarizes some HIM-15 principles for owner's compensation :
  - Owner's compensation means the total benefit received by the owner including salary, amounts paid for the owner's benefit by the facility, the cost of assets and services received from the facility by the owner, and deferred compensation.
  - Reasonableness requires that the owner's compensation be such an amount as would ordinarily be paid for comparable services and must be supported by sufficient documentation such as job descriptions and time sheets to be verifiable and auditable.

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## Basic Cost Principles

- Owner's Compensation (cont'd)
- Necessary requires that had the owner not furnished the services, the institution would have had to employ another person to perform the services.
- §904.2(D)(1) states, "*Presumably, where an owner performs services for several institutions, he spends less than full time with each institution. In such cases, allowable cost shall reflect an amount appropriate to a full-time basis.*" Therefore, owners' compensation is limited to one full time equivalent position in the Louisiana Medical Assistance Program, no matter how many participating facilities the owner may have.
- In addition, owner's compensation is limited by the Bureau of Health Services Financing to the DHH compensation limit for administrators and assistant administrators.

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## Non-allowable costs

- Salaries over DHH limit
  - Provided annually in DHH letter and on DHH website (see Tab 6)
- Owner's and related party's salary not supported by written time documentation
- Dues to more than one professional organization
- Litigation-related legal fees
- Start-up costs are allowable but must be amortized over 60 months

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### Non-allowable Costs

- General Non-allowable Costs
  - Services for which Medicaid recipients are charged a separate fee
  - Depreciation of nonclient care related assets
  - Services that are reimbursable by other state or federally funded programs
  - Goods or services unrelated to client care
  - Unreasonable costs

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### Non-allowable Costs

- Specific Non-allowable Costs
  - Advertising to the general public that seeks to increase client utilization
  - Bad debt expense
  - Contributions/donations
  - Courtesy allowances
  - Board of Director's fees
  - Education costs for clients
  - Gifts
  - Goodwill or interest expense on debt used to acquire goodwill

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### Non-allowable Costs

- Specific Non-allowable Costs
  - Costs of income producing items
    - Fundraising costs
    - Promotional advertising
    - Public relations
  - Income taxes
  - Insurance on officers and key employees not provided to all employees
  - Judgments or settlements of any kind
  - Lobbying cost or political contributions
  - Non-client entertainment

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**Non-allowable Costs**

- Specific Non-allowable Costs
  - Costs related to portions of a facility that are not licensed or certified as Medicaid
  - Officer’s life insurance
  - Payment to parent or other related organization
  - Penalties or sanctions
    - State or Federal
    - NSF fees
  - Personal comfort items
  - Personal use of vehicle

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**Non-allowable Costs**

- Commuting expenses and travel allowances
- Leased or owned vehicles
  - Must have mileage logs if used for both personal and business

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**Income offsets**

- Purchase discounts, allowances, refunds and rebates
- Any income from sale of medical records, scrap or waste, rental of space, etc.
- Interest income
- Special purpose grants (ex., federal food/milk programs)
- Miscellaneous such as gain/loss on assets
- Rental income
- Any income with related expense

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**Attendance Records**

- Affirmative attendance records
  - Should be performed and documented daily
  - Should be maintained by payor type
  - Should record the number of hours attended each day
  - Should reflect monthly totals by client and by payor type
- Days reported on page 2 of the cost report should agree to totals per attendance records
- Census should be supported by:
  - Admission documents
  - Discharge summary/document (other than 148)
  - Nurse’s notes/progress notes, etc.

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**Attendance Records**

- Payment is made for day of admission
- No payment is made for day of discharge
- Payment is limited to 23 days per month and is based on days of actual attendance
- Client must be on-site for 5 or more hours
  - Documented in attendance records
  - Exceptions:
    - Medical appointments
    - Onset of illness
    - Unexpected emergencies

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**Attendance Records**

- If a client has not attended for 30 consecutive calendar days, the client is no longer eligible
  - Must notify DHH with Form 148W
  - Exception – If the absence is due to hospitalization and that hospitalization is documented in the facility’s records (Sec. 2701, F.)

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## Wrap Up

- Summary
- Questions
- Thanks!

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general circulation. If the affected area is Baton Rouge, a single classified advertisement measuring three columns by five inches, in the legal or public notices section of the official journal of the state will be the only public notice required.

A.2. - F.2. ...

3. After the six copies are submitted to the department, a notice shall be placed in the office bulletin (if one is available), the official journal of the state, and a major local newspaper of general circulation. The department shall publish a notice of acceptance for review one time as a single classified advertisement measuring three columns by five inches in the legal or public notices section of the official journal of the state and one time as a classified advertisement in the legal or public notices section of a major local newspaper of general circulation. If the affected area is Baton Rouge, a single classified advertisement measuring three columns by five inches in the official journal of the state shall be the only public notice required. The notice shall solicit comment from interested individuals and groups. Comments received by the administrative authority within 30 days after the date the notice is published in the local newspaper shall be reviewed by the department. The notice shall be published in accordance with the sample public notice provided by the department.

4. - 5. ...

6. Public Notice of a Public Hearing. If the administrative authority determines that a hearing is necessary, a notice shall be published at least 20 days before a fact-finding hearing in the official journal of the state and in a major local newspaper of general circulation. The notice shall be published one time as a single classified advertisement measuring three columns by five inches in the legal or public notices section of the official journal of the state and one time as classified advertisement in the legal or public notices section of a major local newspaper of general circulation. If the affected area is Baton Rouge, a single classified advertisement measuring three columns by five inches in the official journal of the state shall be the only public notice required. Those persons on the department's mailing list for hearings shall be mailed notice of the hearing at least 20 days before a public hearing. A notice shall also be published in the departmental bulletin, if available.

F.7. - G.2. ...

H. Public Notice of Permit Issuance. No later than 10 days following the issuance of a standard permit, the permit holder shall publish a notice of the issuance of the standard permit. This notice shall be published in the official journal of the state and in a major local newspaper of general circulation. The notice shall be published one time as a single classified advertisement measuring three columns by five inches in the legal or public notices section of the official journal of the state, and one time as a classified advertisement in the legal or public notices section of a major local newspaper of general circulation. If the affected area is Baton Rouge, a single classified advertisement measuring three columns by five inches in the official journal of the state will be the only public notice required. The permit holder shall provide proof of publication of the notice(s) to the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2411-2422.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Solid and Hazardous Waste, Solid Waste Division, LR 18:39 (January 1992), amended LR 20:1001 (September 1994), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:2775 (December 2000), LR 27:829 (June 2001), amended by the Office of Environmental Assessment, LR 30:2033 (September 2004).

Wilbert F. Jordan, Jr.  
Assistant Secretary

0409#089

## RULE

### Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

#### Adult Day Health Care (LAC 50:XXI.Chapters 21-39)

Editor's Note: Adult Day Health Care rules have been moved from LAC 50:II.Chapter 109 to LAC 50:XXI.Subpart 2. These rules are being repromulgated to show recodification and new placement.

#### Title 50

### PUBLIC HEALTH MEDICAL ASSISTANCE Part XXI. Home and Community Based Services Waivers

#### Subpart 3. Adult Day Health Care

#### Chapter 21. General Provisions

#### §2101. Forward

A. These standards for participation specify the requirements of the Adult Day Health Care (ADHC) Program. The program is funded as a waived service through Title XIX of the Social Security Act and is administrated by the Department of Health and Hospitals, Bureau of Community Supports and Services (BCSS), in conjunction with other state and local agencies.

B. These standards provide a center with information necessary to fulfill its vendor contract with the State of Louisiana and are the basis for federal and state reviews and surveys.

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 11:623 (June 1985), repromulgated LR 13:181 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1149 (September 1997), repromulgated LR 30:2034 (September 2004).

#### §2103. Program Description

A. An Adult Day Health Care (ADHC) program provides direct care for five or more hours in a 24-hour weekday to individuals who are physically and/or mentally impaired. The target group is those individuals who need direct professional medical supervision or personal care supervision. It is a requirement for program eligibility that such individuals would require intermediate care or skilled nursing services were they not enrolled in an adult day health care center.

B. This program expands the array of services available to functionally-impaired individuals and helps bridge the gap between independence and institutionalization, allowing them to remain in their own homes and communities.

### C. Goals

1. Adult Day Health Care programs work to:
  - a. promote the individual's maximum level of independence;
  - b. maintain the individual's present level of functioning as long as possible, preventing or delaying further deterioration;
  - c. restore and rehabilitate the individual to the highest possible level of functioning;
  - d. provide support and education for families and other caregivers;
  - e. foster socialization and peer interaction;
  - f. serve as an integral part of the community services network and the long-term care continuum of services.

2. The long-range goal for all adult day health care participants is the delay or prevention of 24-hour care.

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 8:145 (March 1982), amended LR 11:623 (June 1985), repromulgated LR 13:181 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 14:793 (November 1988), amended by the Bureau of Health Services Financing, LR 23:1149 (September 1997), repromulgated LR 30:2034 (September 2004).

#### §2105. Definitions

*Adult Day Health Care* group program designed to meet the individual needs of functionally-impaired adults which is structured and comprehensive and which provides a variety of health, social and related support services in a protective setting. *Adult Day Care* and *Adult Day Health Care* are synonymous where they appear in this document.

*Adult Day Health Care Centers Act* 705 of the 1984 Louisiana Legislative Session defines this as: "any place owned or operated for profit or not for profit by a person, agency, corporation, institution or any other group wherein 10 or more functionally-impaired adults who are not related to the owner or operator of the center are received for a portion of the 24-hour day."

*Applicant* an individual whose written application for Medicaid has been submitted to the agency but whose financial or medical eligibility has not yet been determined.

*Attending Physician* refers to a physician, currently licensed by the Louisiana State Board of Medical Examiners, who is designated by the recipient or responsible party as responsible for the direction of the recipient's overall medical care.

*BCSS (Bureau of Community Supports and Services)* the agency within DHH responsible for the administration of home and community based services waivers.

*BHSF (Bureau of Health Services Financing)* the agency within DHH responsible for administering Title XIX (Medicaid) in Louisiana.

*CMS (Centers for Medicare and Medicaid Services)*—the organization within DHHS responsible for administering the Medicaid Program.

*DHH* Department of Health and Hospitals, the state agency responsible for Title XIX (Medicaid) in Louisiana.

*DHHS* the Department of Health and Human Services, the federal agency responsible for administering the Medicaid program.

*Enrollment* the act of registering a licensed and certified center provider into the computerized system for payment of eligible services under the Medical Assistance Program. *Enrollment* includes the execution of the provider agreement and assignment of the provider number used for payment.

*FFP* Federal Financial Participation.

*Functionally-Impaired Adults* those persons who are physically, mentally or socially impaired to the degree that they are in need of medical or personal supervision.

*ICF* Intermediate Care Facility.

*LTC* Long Term Care.

*Medicaid* the medical assistance provided under the state plan approved under Title XIX of the Social Security Act.

*Medicaid Management Information System* the computerized system which lists all providers eligible for participation in the Medical Assistance Program. This system is an organized method of payment for claims for all Title XIX services. It includes all Title XIX providers and all recipients.

*Medical Assistance Program* the division within BHSF specifically responsible for administering Title XIX (Medicaid) in Louisiana.

*Participant*— Title XIX applicant or recipient.

*PASARR*—Preadmission Screening and Annual Resident Review.

*Recipient* an individual who has been found eligible for Title XIX benefits or vendor payments.

*Responsible Party* the individual or group designated by the participant to handle finances or to be called in case of an emergency.

*SNF* Skilled Nursing Facility.

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 11:623 (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 23:1149 (September 1997), amended LR 25:1100 (June 1999), repromulgated LR 30:2035 (September 2004).

#### §2107. Request for Services Registry

A. The responsibility for the waiting list for the Adult Day Health Care (ADHC) Waiver transferred to the Bureau of Community Supports and Services (BCSS) and approximately 27 waiting lists are consolidated into a centralized statewide request for services registry that is maintained by region and arranged in order of the date of the initial request. Persons who wish to be added to the request for services registry shall contact a toll-free telephone number maintained by BCSS. Those persons on the existing waiting lists prior to the date of the transfer of responsibility to BCSS shall remain on the request for services registry in the order of the date on record when the candidate initially requested waiver services. When a candidate is listed on more than one waiting list, the earliest date on record shall be considered the date of initial request.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 28:835 (April 2002), repromulgated LR 30:2035 (September 2004).

## **Chapter 23. Provider Participation**

### **§2301. Provider Agreement**

A. Enrolled Title XIX adult day health care centers shall be licensed by the Department of Health and Hospitals.

B. A provider agreement must be executed wherein the applicant agrees to comply with this Subpart 3, Adult Day Health Care Centers.

C. Each adult day health care center shall enter into a provider agreement with DHH to provide services through Title XIX. An application for enrollment may be obtained by contacting the BCSS.

D. If BCSS has documentation showing good cause (other than lack of funding), it may refuse to execute an agreement with a provider or may cancel an agreement with a certified center.

E. The effective date of the provider agreement shall be no earlier than the effective date the center becomes licensed.

F. The provider agreement shall be limited to one year from the effective date of the previous provider agreement.

G. The provider agrees:

1. to provide adult day health care services to aged and disabled adults who are admitted in accordance with the provider's admission policies;

2. to be licensed by the BCSS as meeting Louisiana licensure standards for payment for adult day health care centers;

3. to not request or accept payment from DHH, BCSS, unless the participant for whom payment is requested is receiving services as specified in this Subpart 3;

4. to notify the BCSS in writing two weeks in advance of changes which would affect this agreement. No such changes shall be effected until written approval is given by BHSF. Information in the BHSF provider enrollment form(s) PE-50 and ownership data shall be kept current with the understanding that:

a. the provider enrollment form(s) and ownership data become a part of this contract and that each succeeding change in the provider enrollment form constitutes an amendment to this contract; and

b. that failure to keep the information current constitutes a breach of the contract making it subject to immediate cancellation;

5. to allow each participant free choice of Medicaid service providers.

H. DHH agrees to make payment to the provider on behalf of eligible recipients if the provider is enrolled in the Medicaid Program as an ADHC center.

I. Both parties mutually agree:

1. that this contract shall be for one year and may be renewed and extended by DHH, BCSS provided compliance is maintained by the provider with licensing standards for adult day health care centers and this Subpart 3, and any and all other rules governing adult day health centers;

2. that DHH, BCSS will renew or extend this contract in a written notice to the provider. Such notice will state the terms and any further conditions for enrollment under which the contract is to be renewed and extended and each such notice shall be incorporated into and become a part of this contract;

3. that this agreement shall not be transferable or assignable;

4. that this agreement shall be performed in a manner consistent with the applicable provisions of Title XIX of the Social Security Act, the provisions of this Subpart 3, and licensing standards for adult day health care centers. Any future modifications or amendments to said Act or said standards shall likewise be binding on the parties hereto;

5. that any breach or violation of any provision of this agreement shall make this entire contract subject to immediate cancellation.

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 11:623 (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 23:1149 (September 1997), amended LR 25:1100 (June 1999), repromulgated LR 30:2036 (September 2004).

### **§2303. Provider Responsibilities**

A. Providers are required to:

1. have appropriate staff chart all medication and treatments administered to participants at the center;

2. maintain adequate records which itemize all charges made to a participant or third party and to make these records available when requested by DHHS, DHH, BCSS, or any other state or federal agency responsible in any way for the administration of Title XIX or state funding for this service;

3. accept, as payment in full, the amounts paid in accordance with established fees for services billed;

4. have a center policy which all employees sign and which specifies that the center does not require or expect or accept tips for services by center employees;

5. immediately notify the participant's attending physician and responsible relative of any emergency involving the participant;

6. promptly (no later than 24 hours) notify the BCSS regional office and BHSF parish offices, in writing, when a participant dies or is discharged from the center;

7. have nursing staff certify to the receipt of prescribed medication by legible signature and agree to comply with all Louisiana law and rules regarding medication control and disbursement;

8. immediately notify the BHSF parish office when the participant requests to see his/her BHSF worker;

9. maintain and keep any records necessary to disclose the extent of services the center furnishes to Medicaid participants and to have such records available for inspection for five years following the end of each three-year waiver period;

10. upon request, to furnish to DHH, DHHS, the attorney general or the Medicaid Fraud Control Unit, or their agents, any information regarding payment claimed by or made to the center for furnishing services to Medicaid recipients;

11. comply with disclosure of ownership and control information and disclosure of information on owners and other persons convicted of criminal offenses against the Medicaid program;

12. operate the center in accordance with the Civil Rights Act of 1964 and its amendments. This means:

a. that individuals are accepted and cared for and that all services and facilities (waiting rooms, toilets, dining

room, and recreation rooms) are available to persons without regard to race, color, age, sex, or national origin; and

b. public facilities are available to visitors without regard to race, color, age, sex, or national origin;

13. submit a quarterly report on personnel to BCSS and to notify appropriate personnel in that division when there is a change in the number of personnel in any classification or any other change that may affect the licensing status of the center;

14. comply with the requirements of this Subpart 3, and state health and safety laws;

15. submit a properly completed cost report within 90 days of the provider's fiscal year closing date. If the cost report is not submitted as required, a penalty of 5 percent of the total monthly payment for each month of noncompliance may be levied. The agency may grant one 30-day extension of the 90-day limit upon request of the provider after having shown just cause. This penalty may be increased by 5 percent for each succeeding month of noncompliance;

16. that if the provider has authorized a representative to enter into this agreement, the provider shall sign and provide DHH, BCSS a copy of an affidavit delegating the said person as agent and authorized representative;

17. that in the event DHH, BCSS determines certain costs which have been reimbursed to the provider pursuant to this or previous agreements are not allowable, DHH shall have the right to recoup and/or set off and/or withhold said amount from amounts due the provider under this agreement for costs that are allowed.

#### B. Incident Reports

1. Incident reports shall be completed for each participant who is:

a. involved in an accident or is injured at the center. This shall include a participant's involvement in any occurrence which has the potential for affecting the welfare of any participant;

b. on elopement status or whose whereabouts is unknown for any length of time.

2. Incident reports shall be compiled into a central record. The fact that the participant was involved in an accident or incident and that an incident report was completed shall be entered into the progress notes of the participant's record by the individual completing the incident report.

3. Incident reports shall include, as a minimum, the following information:

- a. the name of the participant;
- b. the date and time of the incident;
- c. the names of witnesses to the incident;
- d. a detailed description of the incident;
- e. a description of the action taken by the center with regard to the incident.

4. The LPN, with RN or MD consultation, and the center director shall document review of each incident report within 24 hours.

5. At the end of each quarter, the center's interdisciplinary team shall review and analyze the incident reports to:

- a. insure that they contain the information specified Paragraph 3 above;
- b. identify staff training needs;

c. identify patterns which may indicate a need for changes in the center's policies or procedures;

d. assist in the identification of those participants who may require changes in their plans of care or who may not be appropriately placed in the ADHC center.

#### C. Complaint Procedure

1. The DHH complaint procedure shall be posted conspicuously in public areas of the center.

2. Participants shall be encouraged by the center staff to make recommendations and to register complaints with the officials of the center.

#### D. Participant Records

1. All centers shall have written policies and procedures governing access to, duplication of, and dissemination of information from the participant's personal and medical records.

2. The center shall make all necessary participant records available to appropriate state and federal personnel at all reasonable times.

3. Participant records shall include, but shall not be limited to, the following information:

- a. all medical records;
- b. records of all treatments, drugs, and services for which vendor payments have been made, or which are to be made, under the Medical Assistance Program. This includes the authority for and the date of administration of such treatment, drugs or services;

c. sufficient documentation to enable DHH to verify that each charge is due and proper prior to payment;

d. the following physician information:

- i. certification for each participant admission; and
- ii. recertification that the participant requires ICF or SNF services;

e. all records which DHH finds necessary to determine a center's compliance with any federal or state law, or rule promulgated by DHHS or by DHH.

4. Protection of Records. The center shall protect records against loss, damage, destruction, and unauthorized use.

5. Confidentiality of Information. The center shall safeguard the confidentiality of participant information and shall release confidential information only under the following conditions:

- a. by court order; or
- b. by the participant's written authorization, unless contraindicated as documented in the participant's record by the attending physician.

6. Retention of Records. The center shall retain records for whichever of the following time frames is longer:

- a. until records are audited and all audit questions are answered;
- b. three years from the end of the waiver period.

7. Components of Participant Records. The participant's medical record shall consist of the active participant's record and the center's storage files or folders. As this active record becomes bulky, the outdated information shall be removed and filed in the center's storage files or folders. The active medical charts shall contain the following information:

a. at least six months of current pertinent information relating to the participant's active ongoing care;

- b. the necessary admission records; and
- c. if the center is aware that a participant has been interdicted, a statement to this effect shall be noted on the inside front cover of the participant's active participant record.

8. Availability of Participant Records to Center Staff. The center shall insure that participant records are available to staff directly involved with the participant's care.

9. Contents of Participant Medical Records

a. An organized active record system shall be maintained for each participant.

b. All entries made by center staff in participant records shall be legibly signed and fully dated.

c. Each record shall include identifying information:

- i. full name of the participant;
- ii. home address, including street address, city, parish and state;
- iii. Social Security Number;
- iv. Medicaid number;
- v. Medicare claim number, if applicable;
- vi. marital status;
- vii. date of birth;
- viii. sex;
- ix. religious preference;
- x. ethnic group;
- xi. usual occupation (the kind of work the participant engaged in most of working life, even if retired);
- xii. legal status;
- xiii. birthplace;
- xiv. father's name;
- xv. mother's maiden name;
- xvi. dates of service in the United States armed forces, if applicable;
- xvii. personal physician and alternate;
- xviii. participant's choices of other service providers;
- xix. name and address of next of kin or other responsible party;
- xx. admitting diagnoses;
- xxi. any other useful identifying information.

d. Each record shall include medical information. The center shall insure that the participant record contains the following information:

- i. the physician's signed and dated orders, including medication, treatment, diet, and restorative and special medical procedures required for the safety and well-being of the participant. Physician orders shall remain current for a period of one year;
- ii. a comprehensive, interdisciplinary plan of care;
- iii. progress notes;
- iv. discharge plan and discharge (referral) summaries;
- v. current interdisciplinary assessments.

10. Any errors made by the staff in a participant's record shall be corrected using the legal method which is to draw a line through the erroneous information, write "error" by it and initial the correction.

11. Attendance Records

a. The center shall maintain, for no less than three years after the end of the waiver period, records of the dates of each participant's attendance and the number of hours attended each day.

b. Such records shall be kept in a central location.

12. All other records shall be maintained in accordance with the terms of the provider agreement.

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 11:623 (June 1985), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 13:181 (March 1987), LR 23:1150, 1156 and 1163 (September 1997), LR 28:2356 (November 2002), repromulgated LR 30:2036 (September 2004).

**§2305. Medical Certification Application Process**

A. The adult day health care provider must submit a complete admissions packet to BCSS Section within 20 working days of the date of admission.

1. The date of admission or the date of the plan of care, whichever is later, is the effective date of certification. If the admission packet is incomplete, BCSS will issue a denial of certification notice indicating the reason(s) for denial.

2. If the missing information is subsequently received within the 20-day time frame and the applicant meets all eligibility criteria, certification shall be issued retroactive to the date of admission.

3. If the missing information is received after the 20-day time frame and the applicant meets all eligibility criteria, certification shall be issued with an effective date no earlier than the date that all required documents were received by the BCSS.

B. A complete admission packet must contain the following forms:

1. Form 148W which includes the date of Medicaid application if the date of application is later than the date of admission;

2. Form 90-L which is:

a. signed and dated by a physician licensed to practice in Louisiana and includes a level of care recommendation;

b. not completed more than 30 days prior to the date of admission or the date of application if the resident applies for Medicaid after admission.

3. Level I PASARR (Pre-admission Screening/Resident Review):

a. signed and dated by a physician licensed to practice in Louisiana;

b. if a second level screen is indicated due to a diagnosis or suspected diagnosis of mental illness or mental retardation, it must be completed prior to admission;

c. diagnosis and medication on Form 90-L must be consistent with PASARR.

4. Adult Day Health Care Social Assessment (ADHC 1) which:

a. shall not be completed more than 30 days prior to admission;

b. is completed, signed and dated by a master's degreed social worker.

5. Adult Day Health Care Nursing Assessment (ADHC 2) which:

a. shall not be completed more than 30 days prior to admission;

- b. if completed by a licensed practical nurse, it must be countersigned by a registered nurse who must also provide recommendations if necessary;
- 6. plan of care:
  - a. shall not be completed more than 30 days prior to admission;
  - b. shall include:
    - i. problems and needs identified in the assessments;
    - ii. approaches/services to be used for each problem;
    - iii. discipline or job title of staff member responsible for each approach;
    - iv. frequency of each approach/service;
    - v. review/resolution dates; and
    - vi. discharge as a goal.

Note that the diagnosis should not be used as a problem.

- 7. when an individual is presented with a psychiatric disorder, a psychiatric evaluation is required and includes the following components:
    - a. history of present illness;
    - b. mental status;
    - c. diagnostic impression;
    - d. assessment of strengths and weaknesses;
    - e. recommendations for therapeutic interventions;
- and
- f. prognosis;

- 8. when there is a diagnosis of mental retardation/developmental disability, a psychological evaluation is required and includes the following components:
  - a. intellectual quotient; and
  - b. adaptive level functioning.

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 11:633 (June 1985), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1155 (September 1997), repromulgated LR 30:2038 (September 2004).

**§2307. Interdisciplinary Team**

A. The interdisciplinary (ID) team for each center shall be composed of at least the following individuals who may be consultants or center staff:

- 1. a social worker (MSW);
- 2. a registered nurse (RN) licensed to practice in Louisiana;
- 3. the participant;
- 4. at least one direct-care staff person from the center.

B. Responsibilities of ID Team

- 1. The RN and MSW members of the ID team shall, at admission and at least yearly, assess each participant.
- 2. The MSW shall, at admission, assess each participant's home situation to determine which services are required to maintain the integrity of that setting to enable continued placement of the participant. Annually, the MSW shall evaluate the social services designee's (SSD) on-site assessment of the participant's home situation. BCSS Form ADHC-1 shall be used for this assessment.
- 3. The ID team shall develop and update the care plan.
- 4. The ID team shall, at least quarterly, review and analyze incident reports.

5. The RN consultant's responsibilities also shall include at least:

- a. a medication review for each participant at least monthly to determine the appropriateness of the medication regimen. Such a review shall also be done whenever there is a change in the medication regimen;
- b. a monthly review of each participant's medication administration sheet to determine if medications are properly administered in the center;
- c. supervision of the center's plan for self-administration of medication by participants;
- d. health education for staff;
- e. ensuring that diagnoses are compiled into a central location in the participant's record and updated when there is a change.

C. The ID team shall make referrals as indicated to other disciplines and for any other service which would enhance the functional capacity of a participant. The services of physical or speech therapists are available through the Title XIX program and appropriate referrals shall be made when the functional capacity of the participant may be enhanced through provision of such services.

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 11:625 (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 23:1151 (September 1997), repromulgated LR 30:2039 (September 2004).

**§2309. Interdisciplinary Team Assessments**

A. Assessments shall be completed prior to staffing. The primary source of information shall be the participant.

1. Other information may be obtained with the participant's written permission from family, social/medical agencies, and other interested parties unless the participant's rights have devolved.

2. The MSW shall document efforts to involve the primary caretakers in the assessment process.

B. Assessments shall identify the participant's specific strengths, problems and needs particularly in the home, but also in the ADHC setting.

C. Assessments shall be recorded and each participant shall be reassessed at least annually by the MSW and the RN.

D. The social service designee (SSD) of the center shall update the social work assessment on BCSS Form ADHC-1 at least quarterly, and whenever there is a significant change in the home setting which may precipitate 24-hour care.

1. Each update shall involve contact with the participant's primary caretakers.

2. At least annually, the SSD shall update the assessment as a result of a visit to the participant's home and contact with the primary caretakers in that setting.

E. The physician assessment shall be done annually. The BHSF Form 90-L shall be used for this assessment.

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 11:625 (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 23:1152 (September 1997), repromulgated LR 30:2039 (September 2004).

### §2311. Staffings

A. Staffings shall be conducted in a group meeting including:

1. the participant;
2. at least one center staff member; and
3. the ID team.

B. After initial assessment by the ID team, each participant shall be individually staffed to develop a viable plan of care for the participant.

C. The participant is the primary source of information during staffing. In the event the requirements of 2901.E have been met, the primary caretaker of the participant or responsible party in the home serves in this capacity.

D. A staffing for each participant shall be conducted at least quarterly, and whenever the recipient situation resolves more than 25 percent of the problems, goals or approaches in the care plan. It is not necessary to staff the participant when there is a simple change in the care plan, such as a minor change in medication or a minor change in the approach for a specific goal. In such cases, the ID team member and center staff responsible for the goal/approach shall revise the plan and initial and date the change.

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 11:625 (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 23:1152 (September 1997), repromulgated LR 30:2040 (September 2004).

### §2313. Plan of Care

A. All services shall:

1. be provided according to the individual written plan of care which is reviewed and updated;
2. be a result of an interdisciplinary staffing in which the participant and direct care staff participate;
3. be written in terminology which all center personnel can understand;
4. list the identified problems and needs of the participant for which intervention is indicated, as identified in assessments, progress notes and medical reports;
5. propose a reasonable, measurable short-term goal for each problem/need;
6. contain the necessary elements of the center's self administration of medication plan, if applicable;
7. use the strengths of the participant in developing approaches to problems;
8. specify the approaches to be used for each problem and that each approach is appropriate to effect positive change for that problem;
9. identify the staff member responsible for carrying out each approach;
10. project the resolution date or review date for each problem;
11. specify the frequency of each approach/service;
12. contain a sufficient explanation of why the participant would require 24-hour care were he/she not receiving ADHC services;
13. include the number of days and time of scheduled attendance each week;
14. include discharge as a goal;
15. be kept in the participant's record used by direct care staff.

B. At least 75 percent of the services contained in the care plan shall be from among those listed in 2501.C and in no event shall more than 25 percent be from 2501.D.

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 11:625 (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 23:1152 (September 1997), repromulgated LR 30:2040 (September 2004).

### §2315. Progress Notes

A. Progress notes are ongoing assessments of the participant which enable staff to update the plan of care in a timely, effective manner. Each individual responsible for providing direct services shall record progress notes at least monthly.

B. All progress notes shall:

1. provide documentation that staff are carrying out the approaches in the care plan for which each is responsible;
2. record progress made and discuss whether or not the approaches in the care plan are working;
3. document delivery of any service identified on the care plan;
4. record any changes in the participant's medical condition, behavior or home situation which may indicate a need for a care plan change;
5. document that incident reports have been completed when appropriate;
6. be legibly signed and fully dated.

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 11:625 (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 23:1153 (September 1997), repromulgated LR 30:2040 (September 2004).

## Chapter 25. Services

### §2501. Mandatory Services

A. The ultimate goal of all services provided is greater independence and community involvement to enable prevention or delay of 24-hour institutional care.

B. All nursing and social services shall be provided in accordance with acceptable professional practice standards for each discipline.

C. As a minimum, each center shall make available the following required services:

1. usage of reality orientation by all staff, as well as daily orientation classes;
2. individualized training in the activities of daily living (toileting, grooming, etc.);
3. interdisciplinary team staffing;
4. health and nutrition counseling;
5. professional social work services;
6. an individualized exercise program;
7. an individualized, goal-directed recreation program;
8. health education classes;
9. daily individualized health services to include at least nursing services that consist of:
  - a. monthly assessment of each participant's medication regimen to evaluate contraindications, the need for appropriate laboratory monitoring and referrals to the

attending physician for such tests and the efficacy of the drugs prescribed;

b. monitoring of vital signs appropriate to the diagnosis and medication regimen of each participant but no less frequently than monthly;

c. administration of medications and treatments in accordance with physician orders and acceptable nursing practice standards;

d. a self administration of medication plan for the center which is individualized for each participant for whom it is indicated;

e. serving as a coordinator and advocate between the participant and medical resources, including the treating physician;

10. individualized leisure skill development and education;

11. one nutritionally balanced hot meal each day and two snacks. This service shall be provided in accordance with the nutritional needs of the participant. Liquids shall be available and easily accessible;

12. intellectual and educational development opportunities (bookmobile, talking library, etc.);

13. transportation to and from the center at the beginning and end of the program day.

D. Only the following additional services and activities shall be reimbursed by BHSF:

1. field trips (intellectual and emotional stimulation);
2. volunteer group visits (emotional stimulation);
3. meal preparation (functional capacity);
4. taping of oral histories (intellectual stimulation);
5. participant interaction with volunteers other than those serving as staff in the center (emotional stimulation);
6. bill paying and letter writing sessions (functional capacity stimulation);
7. films at the center (intellectual stimulation);
8. sing-alongs (social interaction and stimulation);
9. recording of nutritional intake (functional capacity);
10. educational and recreational films (intellectual and emotional stimulation and functional capacity);
11. educational lectures (functional capacity);
12. assistance with obtaining, utilizing and maintaining food stamps, grants and other economic stabilization activities;

13. transportation to and from social/medical services.

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 23:1153 (September 1997), repromulgated LR 30:2040 (September 2004).

## **Chapter 27. Participant Eligibility**

### **§2701. Eligibility for Certification**

A. The individual must meet the level of care criteria for SNF, ICF I or ICF II care found in this Subpart 3.

B. It must be determined by BCSS at admission and during utilization review (UR) that the individual's home setting would not suffice as a placement unless ADHC services were being provided.

C. It must be determined by BHSF at admission and during UR that health and other services will be provided according to an approved written plan of care.

D. The individual must meet categorically-related eligibility requirements as specified in Title XIX of the Social Security Act.

E. No recipient of medically needy benefits shall be simultaneously eligible for adult day health care services. Recipients of inpatient hospital, ICF I, ICF II or ICF/H, or SNF services shall not be simultaneously eligible for ADHC services.

F. An individual who has not attended a center for 30 consecutive calendar days or more shall not be eligible for ADHC services. An exception to this is the individual who is absent from the center because of hospitalization or an illness which is documented in the center's records.

G. After an individual has been absent 30 consecutive calendar days, the center shall, within 24 hours, notify both the BHSF parish and regional BCSS offices by BCSS Form 148W.

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 11:627 (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 23:1155 (September 1997), LR 24:457 (March 1998), repromulgated LR 30:2041 (September 2004).

## **Chapter 29. Patient Rights**

### **§2901. Recipient Rights/Privileges**

A. The staff of each center shall be trained to protect the rights of the participants.

B. Before or upon admission, or upon adoption of participant rights policies by the center, each participant shall be provided a copy of and explained the center's participant rights policy and any amendments.

C. Each participant shall acknowledge receipt of this document, in writing, and the acknowledgment shall be filed in the participant's record. Two witnesses shall be required if the participant signs with a mark or is mentally retarded. The mark shall be bracketed and identified as indicated below:

HER (X) MARK

MARY JONES

WITNESS

WITNESS

D. Participant rights shall include at least the following items.

1. Each participant shall be informed of his/her responsibilities to the center and of all rules governing participant conduct and behavior. The regulations of the center shall be fully explained.

2. If the center changes its participant rights policies, each participant shall acknowledge, in writing, receipt of the change and the acknowledgment shall be filed in the participant's records.

3. Each participant shall be informed, in writing, of all services available in the center. The charges for these services shall be specified when they are not covered in the center's basic Title XIX rate per day. Receipt of this information and any changes in it shall be acknowledged by the participant, in writing, and the acknowledgment shall be filed in the participant's record.

4. Each participant shall be provided the opportunity to participate in each interdisciplinary staffing meeting and any other meeting involving the care of the participant.

5. Each participant shall be afforded the opportunity to refuse any service provided in the center.

6. Each participant shall give informed, written consent before participating in experimental research or any studies conducted at the center.

7. Each participant shall be encouraged and assisted to exercise his/her rights as a participant at the center and as a citizen.

8. Each participant shall be allowed to submit complaints or recommendations about the policies and services of the center to staff or to outside representatives. Participants shall be allowed to do this free from restraint, interference, coercion, discrimination or reprisal.

9. Each participant shall be free from mental and physical abuse.

10. Each participant shall be free from physical restraint.

a. Physical restraint shall be used only when ordered by the attending physician.

b. The physician's order for restraint shall be filed in the participant's record. Specify the reason for using restraint and include a specific time frame for using restraint.

c. Participants who are mechanically restrained shall be monitored at least every 30 minutes to insure that circulation is not impaired and that positioning is comfortable.

d. Participants being mechanically restrained shall be released and be provided the opportunity for exercise at least every two hours. Center staff shall document this activity each time the participant is released.

e. Physical restraint may be used without a physician's order in an emergency only under the following conditions:

i. use of restraint is necessary to protect the participant from injuring himself/herself or others;

ii. use of restraint is authorized by the individual who is identified in the written policies and procedures as having the authority to do so;

iii. use of restraint is reported at once to the attending physician by the staff person referred to in Clause ii above.

11. Each participant shall be treated with consideration, respect and full recognition of his or her dignity and individuality.

12. Each participant shall be afforded privacy during the provision of personal needs services.

13. No participant shall be required to perform services for the center. This shall be allowed by the center only when a specific service is identified in the plan of care as an appropriate approach to a need or problem of the participant.

14. Each participant shall be allowed to communicate, associate, and meet privately with individuals of his/her choice, unless this infringes on the rights of another participant.

E. Development of Participant Rights. Under the following conditions, the center shall insure that participant rights devolve to the responsible party, next of kin or sponsoring agency. If the participant rights have devolved to the responsible party, next of kin or sponsoring agency, that party shall receive the explanation of and sign the participant rights and any other documents described in these standards.

1. The participant has been interdicted in a court of law. In such cases, the center shall insure that the

participant's rights devolve to the curator/curatrix of record and that the interdiction is documented on the inside front cover of the participant's record. The center shall have an official document verifying the participant has indeed been interdicted.

2. The participant's attending physician signs a statement at least quarterly that the participant is unable to exercise his/her Title XIX participant rights because of a specific medical diagnosis. In such cases, the center shall insure that participant rights devolve to the responsible party of record (Form 90-L).

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).

## **Chapter 31. Reimbursement**

### **Subchapter A. Prospective Payment System**

#### **§3101. General Provisions**

A. Development. Adult Day Health Care (ADHC) providers shall be reimbursed a per diem 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 adult day health care recipients by ensuring that direct care services are provided at an acceptable level while fairly reimbursing the providers.

B. The prospective payment methodology establishes blended rates consisting of 50 percent of the PPS rate based on the median FY 2001 reported cost for all ADHC providers filing acceptable full year cost reports and 50 percent of the facility specific prospectively determined rate based on facility specific reasonable allowable costs.

#### C. Cost Centers

1. Direct Care Costs. This component reimburses for in-house and contractual direct care staffing and fringe benefits and direct care supplies.

2. Care Related Costs. This component reimburses for in-house and contractual salaries and fringe benefits for activity and social services staff, raw food costs and care related supplies for activities and social services.

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

a. utilities;

b. accounting;

c. dietary;

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.

D. Rate Setting. Adult day health care providers shall be reimbursed blended rates consisting of 50 percent of the PPS rate based on the median FY 2001 reported cost for all ADHC providers filing acceptable full year cost reports and 50 percent of the facility specific prospectively determined

rate based on facility specific reasonable allowable costs plus a direct care incentive.

1. The PPS rate is based on the median FY 2001 reported cost for all ADHC providers filing acceptable full year cost reports.

a. Direct Care Costs. A statewide base rate for direct care is computed at 115 percent of the median facility per diem direct care costs submitted on all full year cost reports except those for which an audit disclaimer has been issued. Direct care costs are trended forward using the Consumer Price Index (CPI) Medical Services.

b. Care Related Costs. A statewide base rate for care related costs is computed at 105 percent of the median facility per diem care related costs submitted on all acceptable full year cost reports except those for which an audit disclaimer has been issued. Care related costs are trended forward using the CPI All Items.

c. Administrative and Operating Costs (AOC). A statewide base rate for administrative and operating costs is computed at 105 percent of the median facility per diem administrative and operating costs submitted on all acceptable full year cost reports except for those for which an audit disclaimer has been issued and are trended forward using the CPI All Items.

d. Property. The property rate is computed at the median of property costs submitted on all acceptable full year cost reports. Inflation will not be added to property costs.

2. The facility specific prospectively determined rate is based on facility specific reasonable allowable costs. The facility specific prospectively determined rate shall be limited to 80 percent of the nursing facility intermediate care II rate in effect on July 1, 2002 exclusive of the provider fee.

a. Direct Care Costs. Facility specific direct care is based on the facility specific per diem reasonable allowable direct care costs submitted on the acceptable FY 2001 full year cost report. Direct care costs are trended forward using the Consumer Price Index (CPI) Medical Services.

b. Care Related Costs. Facility specific care related cost is based on the facility specific per diem reasonable allowable care related costs submitted on the acceptable FY 2001 full year cost report. Care related costs are trended forward using the CPI All Items.

c. Administrative and Operating Costs (AOC). Facility specific AOC is based on the facility specific per diem reasonable allowable AOC submitted on the acceptable FY 2001 full year cost report. AOC are trended forward using the CPI All Items.

d. Property. Facility specific property cost is based on the facility specific per diem reasonable allowable property costs submitted on the acceptable FY 2001 full year cost report. Inflation will not be added to property costs.

e. Facilities participating prior to August 1, 2003 who have not filed a full year acceptable cost report shall have the facility specific prospectively determined rate for August 1, 2003 through June 30, 2004 based on budgeted data and limited to 80 percent of the nursing facility weighted average case mix rate in effect on July 1, 2003.

f. For rates effective July 1, 2004 and thereafter, facilities receiving audit disclaimers shall receive a rate equal to the PPS rate based on the median FY 2001 reported

cost for all ADHC providers filing acceptable full year cost reports trended forward in accordance with this §3101.

3. All trending shall be from the mid-point of the year preceding the cost report year to the midpoint of the year preceding the rate year.

4. Application of an inflationary adjustment to reimbursement rates in non-rebasing years shall apply only when the legislature allocates funds for this purpose.

5. A direct care incentive based on legislative appropriation shall be added to the per diem rate effective August 1, 2003.

E. Total Per Diem Rate. The per diem rate for providers filing acceptable full year cost reports is the sum of 50 percent of the PPS rate based on the median FY 2001 reported cost for all ADHC providers filing acceptable full year cost reports plus 50 percent of the facility specific prospectively determined rate based on facility specific reasonable allowable costs plus the direct care incentive.

F. New providers enrolled in the Medicaid Program effective August 1, 2003 and thereafter shall receive the PPS rate based on the base year median reported cost for all ADHC providers filing acceptable cost reports trended forward in accordance with this §3101 plus the direct care incentive.

G. Minimum Rate. The minimum adult day health care rate shall be the PPS rate based on the median FY 2001 reported cost for all ADHC providers filing acceptable full year cost reports plus the direct care incentive.

H. Cost Settlement. The direct care cost component and the direct care incentive shall be subject to cost settlement. Should an ADHC facility's cost report reveal that the provider did not expend an amount equal to 90 percent of the median direct care rate component trended forward for direct care services plus 90 percent of the direct care incentive, the Medicaid program will recover the difference between 90 percent of the median direct care rate component trended forward for direct care services plus 90 percent of the direct care incentive and the actual direct care amount expended.

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 28:2356 (November 2002), amended LR 30:242 (February 2004), repromulgated LR 30:2042 (September 2004).

### §3103. Cost Reporting

A. Providers of ADHC services are required to file annual acceptable cost reports of all reasonable and allowable costs. An acceptable cost report is one that is prepared in accordance with the requirements of this §3103 and 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 facility for no less than five years following the date reports are submitted to the Bureau. A chart of accounts and an accounting system on the accrual basis or converted at year end are required in the cost reporting 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 facilities 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.

B. The cost reporting forms and instructions developed by the Bureau must be used by all ADHC facilities 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. 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.

C. Annual Reporting. Cost reports are to be filed on or before the last day of September following the close of the 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 in duplicate together with two copies of the following documents:

1. a working trial balance that includes the appropriate cost report line numbers to which each account can be traced. This may be done by writing the cost report category and line numbers by each ending balance or by running a trial balance in cost report category and line number order that totals the account;

2. a depreciation schedule. If the facility has different book and Medicaid depreciation schedules, copies of both depreciation schedules must be submitted. If the facility has home office costs, copies of the home office depreciation schedules must also be submitted. All hospital based facilities must submit two copies 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 or a copy of contracts for managed services, if applicable;

6. a narrative description or a copy of the contracts for management services provided by a related party or home office, a description of the basis used to allocate the costs to providers of the group and to nonprovider activities and copies of the cost allocation worksheet, if applicable. Costs included that are for related management/home office costs must also be reported on a separate cost report that includes an allocation schedule;

7. all allocation worksheets must be submitted by hospital-based facilities. The Medicare worksheets that must be attached by facilities 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 I; and
- g. B-1.

D. Each copy of the cost report must have the original signatures of an officer or facility 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.

E. 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 or cost findings that are not submitted.

F. Accounting Basis. The cost report must be prepared on the accrual basis of accounting. If a facility 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 the equitable distribution of costs to the applicable 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 reporting period.

G. 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 facility 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.

H. Nonacceptable 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.

I. Exceptions. Limited exceptions to the cost report 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, providers 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. For the initial reporting period only, the provider may allocate costs to the various cost centers on a reasonable basis if the required itemized cost breakdown is not available.

2. If the center has been purchased, leased or has effected major changes in the accounting system as an ongoing concern within the reporting period, a partial year cost report may be filed in lieu of the required 12-month report.

3. 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.

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 28:2356 (November 2002), amended LR 30:243 (February 2004), repromulgated LR 30:2043 (September 2004).

### **§3105. Cost Categories Included in 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 resident 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 residents.

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 residents.

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 facility employees.

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

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

14. Drugs, Over-the-Counter and Legend cost of over-the-counter and legend drugs provided by the facility to its residents. This is for drugs not covered by Medicaid.

15. Medical Supplies cost of patient-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. Other Supplies, DC cost of items used in the direct care of residents which are not patient-specific such as prep supplies, alcohol pads, betadine solution in bulk, tongue depressors, cotton balls, thermometers, and blood pressure cuffs.

18. 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.

19. Total Direct Care Costs sum of the above line items.

#### **B. Care Related 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. Barber and Beauty Expense the cost of barber and beauty services provided to patients for which no charges are made.

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

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

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

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

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

14. Food, Raw cost of food products used to provide meals and snacks to residents. 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 patients of the facility. 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. 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 facilities must attach a schedule of the administrator's salary before allocation, the allocation method, and the amount allocated to the nursing facility.

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, Drivers gross salaries of personnel involved in transporting clients to and from the facility.

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

8. Salaries, Owner or Owner/Administrator gross salaries of all owners of the facility that are paid through the facility.

9. 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.

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

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

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

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

14. Contract, Dietary cost of dietary services and personnel hired through contract that are not employees of the facility.

15. Contract, Housekeeping cost of housekeeping services and personnel hired through contract that are not employees of the facility.

16. Contract, Laundry cost of laundry services and personnel hired through contract that are not employees of the facility.

17. Contract, Maintenance cost of maintenance services and persons hired through contract that are not employees of the facility.

18. Consultant Fees, Dietician fees paid to consulting registered dietitians.

19. 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 facility and other related services excluding personal tax planning and personal tax return preparation.

20. 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 nonallowable costs. If allowable cost is reported on this line, an amortization schedule must be submitted with the cost report.

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

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

23. Dues dues to one organization are allowable.

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

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

26. Insurance, Professional Liability and Other includes the costs of insuring the facility against injury and malpractice claims and the cost of vehicle insurance.

27. Interest Expense, Non-Capital and Vehicles interest paid on short term borrowing for facility operations and on vehicle loans.

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

29. Legal Fees only actual and reasonable attorney fees incurred for nonlitigation legal services related to patient care are allowed.

30. Linen Supplies cost of sheets, blankets, pillows, gowns, underpads and diapers (reusable and disposable).

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

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

33. Nonemergency Medical Transportation the cost of purchased nonemergency medical transportation services including, but not limited to, payments to employees for use of personal vehicle, ambulance companies and other transportation companies for transporting patients of the facility.

34. 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, facility letterhead and billing forms;
- c. cost of subscribing to newspapers, magazines and periodicals.

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

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

37. Taxes and Licenses the cost of taxes and licenses paid that are not included on any other line on Form 6. This includes tags for vehicles, licenses for facility staff (including nurse aide recertifications) and buildings.

38. Telephone and Communications cost of telephone services, wats lines and fax services.

39. 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 facility business. Commuting expenses and travel allowances are not allowable.

40. Vehicle Expenses vehicle maintenance and supplies, including gas and oil.

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

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

43. Total Administrative and Operating Costs

D. Property and Equipment

1. Amortization Expense, Capital legal and other costs incurred when financing the facility 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 facility'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 facility's land, buildings and/or furniture and equipment, excluding vehicles.

4. Property Insurance cost of fire and casualty insurance on facility buildings and equipment, excluding vehicles. Hospital-based facilities and state-owned facilities must allocate property insurance based on the number of square feet.

5. Property Taxes taxes levied on the facility's buildings and equipment, excluding vehicles. Hospital-based facilities and state-owned facilities must allocate property insurance based on the number of square feet.

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

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

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

9. 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.

10. Total Property and Equipment.

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 28:2356 (November 2002), repromulgated LR 30:2045 (September 2004).

**§3107. Nonallowable Costs**

A. Costs that are not based on the reasonable cost of services covered under Medicare and are not related to the care of beneficiaries are considered nonallowable costs.

B. Reasonable cost does not include the following:

1. costs not related to client 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. cost exceeding what a prudent and cost-conscious buyer would incur to purchase the goods or services.

C. General Nonallowable Costs:

1. services for which Medicaid recipients are charged a fee;
2. depreciation of nonclient care assets;

3. services that are reimbursable by other state or federally funded programs;
4. goods or services unrelated to client care;
5. unreasonable costs.

D. Specific Nonallowable Costs (this is not an all inclusive listing):

1. advertising costs of advertising to the general public that seeks to increase patient 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 clients;
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. nonclient entertainment;
15. nonMedicaid-related care costs costs allocated to portions of a facility 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, the Internal Revenue Services or the state Tax Commission; insufficient funds charges;
19. personal comfort items;
20. 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 and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2356 (November 2002), repromulgated LR 30:2047 (September 2004).

### §3109. Provider Reimbursement

#### A. Cost Determination Definitions

*Adjustment Factor* is 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).

*Base Rate* is calculated in accordance with Paragraph B.5 of this §3109, plus any base rate adjustments granted in accordance with Paragraph B.7 of this §3109 which are in effect at the time of calculation of new rates or adjustments.

*Base Rate Components* the base rate is the summation of the following:

- a. direct care;
- b. care related costs;
- c. administrative and operating costs;
- d. property costs.

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.

#### B. Rate Determination

1. Calculation of base rate rates for both the PPS rate based on the median FY 2001 reported cost for all ADHC providers filing acceptable full year cost reports and the facility specific prospectively determined rate based on facility specific reasonable allowable costs are calculated from cost report data. 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. These general cost principles include determining whether the cost is ordinary, necessary, and related to the delivery of care; the cost is 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 the cost is for goods or services actually provided to the center. Through the desk review and/or audit process, adjustments and/or disallowances may be made to a provider s reported costs. HIM-15 , the Medicare Provider Reimbursement Manual, is the final authority for allowable costs unless the Louisiana Department of Health and Hospitals has set a more restrictive policy.

2. Audited and desk reviewed costs for each component are ranked by facility to determine the value of each component at the median.

3. The median costs for each component are multiplied in accordance with 3101.D then by the appropriate economic adjustment 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 economic adjustment factors, unless they are adjusted as provided in Paragraph B.7 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 per diem costs from all acceptable full year cost reports 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 using the Consumer Price Index for Medical Services. The direct care rate component shall be set at 115 percent of the inflated median.

b. Care Related Cost Component. Care related per diem costs from all acceptable full year cost reports 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 using the Consumer Price Index for All Items. The care related rate component shall be set at 105 percent of the inflated median.

c. Administrative and Operating Cost Component. Administrative and operating per diem cost from all acceptable full year cost reports 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 index for December of the year proceeding 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 Property. The property per diem costs from all acceptable full year cost reports shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. This will be the rate component. Inflation will not be added to property costs.

7. Formulae. Each facility specific prospectively determined cost component shall be calculated as follows.

a. Direct Care Cost Component. The direct care per diem costs from each facility's full year cost reports shall be trended forward using the Consumer Price Index for Medical Services in accordance with this §3109.

b. Care Related Cost Component. The care related per diem costs from each facility's full year cost reports shall be trended forward using the Consumer Price Index for Medical Services in accordance with this §3109.

c. Administrative and Operating Cost Component. The administrative and operating per diem cost from each facility's acceptable full year cost reports shall be trended forward using the Consumer Price Index for Medical Services in accordance with this §3109.

d. Property Cost Component Property. The property per diem costs from each facility's acceptable full year cost reports shall be the property cost component. Inflation will not be added to property costs.

e. Facilities participating prior to August

1, 2003 who have not filed a full year acceptable cost report shall have the facility specific prospectively determined rate for August 1, 2003 through June 30, 2004 based on budgeted data and limited to 80 percent of the nursing facility weighted average case mix rate in effect on July 1, 2003.

f. For rates effective July 1, 2004 and

thereafter, facilities receiving audit disclaimers shall receive a rate equal to the PPS rate based on the median FY 2001 reported cost for all ADHC providers filing acceptable full year cost reports trended forward in accordance with this rule. No facility specific cost component will be included in the per diem of facilities receiving audit disclaimers.

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 Bureau 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 Bureau, however, may initiate a rate change without a request to do so. Changes to the rates may be one of two types: temporary adjustments; or base rate adjustments as described below.

a. Temporary Adjustment. 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.

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 28:2356 (November 2002), amended LR 30:243 (February 2004), repromulgated LR 30:2048 (September 2004).

#### **Subchapter B. Admission Assessment/Vendor Payment**

##### **§3121. BHSF Admission Assessment/Vendor Payment**

A. Vendor payment shall only be made by DHH in accordance with the terms of each provider agreement.

B. Vendor payment shall not be made retroactively prior to the date each participant is staffed and a current, adequate care plan developed.

C. Vendor payment for service days for a participant shall be limited to 23 days per month.

D. Vendor payment for services provided is dependent upon the quality of services provided and each center's compliance with this Subpart 3.

E. Vendor payment shall be limited to those days the participant receives services on-site for five or more hours as documented by center attendance records. Exceptions to attendance for the full day or major fraction thereof shall be for medical appointments, onset of illness after arrival at the adult day health care center, and unexpected emergencies such as a death in the family or acts of God.

F. DHH may withhold vendor payments in whole or in part in the following situation.

1. Change in Center Status. A minimum of 10 percent of the final vendor payment due a center may be withheld pending completion of an audit. The following are situations which shall warrant 10 percent withholding:

- a. a change of ownership;
- b. a center voluntarily ceases to participate in Title XIX;
- c. a center is decertified for Title XIX;
- d. a center's license is revoked or not renewed;
- e. a center's provider enrollment agreement is canceled.

2. Incorrect or Inappropriate Charges to Participants. When DHH determines that a center has violated a provider agreement by incorrectly or inappropriately charging a participant or responsible party, a sum not to exceed the inappropriate charges shall be withheld until the provider:

- a. makes restitution to the participant or responsible party;
- b. submits evidence of restitution to BHSF and the fiscal intermediary.

3. Delinquent Cost Report

a. When a center fails to submit a properly completed cost report within 90 days of its accounting period or fiscal year end, a penalty of 5 percent of each total monthly payment shall be withheld until the properly completed cost report is submitted.

b. DHH may grant one extension, not to exceed 30 days, of the 90-day limit if evidence of just cause has been provided and established in writing.

c. The 5 percent penalty may be increased by 5 percent each month if the provider does not demonstrate good faith in producing a properly completed cost report.

G. Deferral or Disallowance of FFP

1. Should CMS defer or disallow FFP to the state for one or more adult day health care center's deficiencies, lack of compliance with waiver provisions, fraud or other reasons identified by CMS, the state shall defer or disallow the sums involved by withholding and/or recoupment from the adult day health care centers involved.

2. Should CMS restore in whole or in part to DHH, BCSS the amounts deferred or disallowed, DHH, BCSS shall restore the appropriate amount to the provider.

H. Termination of the Waiver

1. Should CMS terminate the waiver under which the Adult Day Health Care Program is operated, DHH shall notify each participating provider and, after receipt of such notice, no further reimbursement will be made.

2. If the state chooses to totally fund adult day health care services, reimbursement for services may be made as provided by the state.

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 11:633 (June 1985), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1155 (September 1997), repromulgated LR 30:2049 (September 2004).

**Chapter 33. Quality Assurance Monitoring**  
**§3301. Utilization Review**

A. The BCSS regional offices shall conduct utilization review (UR) of each participant's need for continued ICF or SNF care at least annually.

B. For newly enrolled centers, the UR date shall be 12 months from the effective date of certification as a Title XIX provider.

C. For centers which have been previously reviewed, the UR date shall be 12 months from the date of the previous exit conference.

D. If at all possible, UR shall be conducted in conjunction with inspection of care.

E. The interval between UR exit conference dates shall not exceed 12 months.

F. Composition of UR Team

1. The UR team shall be composed of at least one social worker and one registered nurse, both of whom conduct the on-site review.

2. The UR team shall not include any individual who has a financial interest in or who is employed by any long term care provider.

3. The team leader may be either the RN or the social worker.

G. Center Responsibilities. See 3303 for the center's responsibilities during any review.

H. UR Team Responsibilities

1. If the UR is conducted in conjunction with an Inspection of Care, refer to 3303 for team responsibilities.

2. If the UR is conducted independently of the Inspection of Care, the UR team has the following responsibilities.

a. If the team elects to notify the center of the review, this shall be done no more than 24 hours prior to the inspection. It is recommended that the center not be notified.

b. The team shall insure that it has a current list of all Title XIX eligibles and applicants receiving services from the center. This shall include participants for whom vendor payments to the center are not being made but who are eligible for Medicaid.

c. The team shall hold an entrance conference with the center director or designee which shall cover the following points:

- i. the purpose of the review;
- ii. the specific materials needed for review;
- iii. the expected duration of the review and whether the review may be interrupted by the team;
- iv. notification that an exit conference will be held at the conclusion of the review.

d. The team shall assess each participant's continued need for ICF or SNF services. Materials to be reviewed for this purpose shall include:

i. a current (completed within 12 months) physician certification of the need for the specific level of care for which the participant is certified;

ii. a current (completed within one year and reviewed and updated at least quarterly) plan of care which includes the information specified in 2313.

iii. current (completed at least quarterly) social work assessments and updates;

iv. other material needed to determine the need for continued stay at the certified level of care;

v. the discharge plan.

e. The team shall determine if each Title XIX applicant or recipient continues to meet the criteria specified in 2701.

f. The team shall review time and attendance records to insure that no participant was absent for a period of 30 or more calendar days without the center fulfilling its responsibilities to notify BHSF parish and BCSS regional offices. If the team finds that a participant was absent for a period of 14 or more calendar days, and the center did not fulfill its responsibilities to notify BHSF parish and BCSS regional offices, the center shall be cited.

g. If the team finds that the participant continues to meet those criteria, Form 51NH shall be issued assigning a review date 12 months from the date of the exit conference. The team shall sign and approve the current care plan.

h. If the team finds that a participant no longer meets the criteria in 2701, Form 142W shall be completed denying continued medical certification.

i. Item II.A. on Form 142W should be checked and completed as follows: "Medicaid payment will continue for above type services through the period of advance notice."

ii. Advance notice of closure and participant appeal rights shall be sent by the parish office when the vendor payment is closed.

iii. The center shall implement discharge of the participant during the effective period of the advance notice.

i. When a participant's record lacks sufficient or current data on which to base a determination, the center shall be cited in the utilization review report.

j. Prior to the exit conference, the team shall compile a list of participants who no longer require ADHC services and a list of those participants for whom a determination could not be made.

k. An exit conference shall be held to provide a verbal report of the team's findings. The conference shall include at least:

i. a description of the deficiencies identified during the review;

ii. the names of those individuals found to no longer require ADHC services;

iii. the names of those individuals for whom a determination could not be made;

iv. that the information necessary to make a determination shall be forwarded to the regional office, within 25 days of the exit conference date, the medical certification of the participant shall be terminated.

l. If the requested material for utilization review is not received by the regional office within that time frame, under no circumstances is an ADHC recipient to remain

certified for Title XIX for more than 30 days when the need for continued stay cannot be determined.

i. Form 142W shall be issued terminating medical certification.

ii. Item II.A of Form 142W should be checked and completed as follows: "Medicaid payment will continue for above type services through the period of advance notice."

m. A review report shall be prepared whether or not deficiencies were identified during the utilization review. This report shall contain all of the information required by established DHH procedure and shall be submitted to the center within the time frame specified in that procedure.

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 11:628 (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 23:1157 (September 1997), repromulgated LR 30:2050 (September 2004).

### **§3303. Inspection of Care**

A. At least annually, each center with at least one Medicaid recipient or applicant participating shall be inspected.

1. If at all possible, this inspection shall be conducted in conjunction with UR.

2. If the team elects to notify the center of the review, this shall be done no more than 24 hours prior to the inspection.

3. It is recommended that the center not be notified.

4. DHH reserves the right to inspect any center at any time without prior notification.

B. Purpose of Inspection. Inspections of Care shall be conducted to determine if Medicaid recipients or applicants in Title XIX enrolled Adult Day Health Care centers are, in fact, receiving health, social, recreational, nursing and personal care services that are:

1. optimal in quality;

2. adequate in quantity;

3. sufficient in scope; and

4. being provided in a timely manner under circumstances most favorable to the promotion of physical, social, emotional and functional well being of each Medicaid recipient.

C. Composition of Inspection Team. The team shall be composed as specified in 3301.F.

D. Frequency of Inspections

1. Each center shall be inspected at least annually; however, the frequency of inspections shall be based on the quality of care and services provided by a center as determined by state reviews and surveys and complaints investigated.

2. The quality of care determination by BHSF is based on the degree to which a center complies with:

a. this Subpart 3;

b. the fiscal integrity with which the center is administered; and

c. licensing surveys.

E. Follow-up Reviews

1. When an Inspection of Care results in a determination that serious deficiencies exist in a center, a follow-up review shall be conducted between 15 and 45 days

after the inspection to determine if adequate corrective action has been taken.

2. Inspection team responsibilities during a follow-up review are as outlined in this 3303 except that:

a. at least a 10 percent sample of Title XIX recipients and applicants shall be reviewed;

b. only the areas in which the center was found deficient shall be reviewed.

3. Follow-up reviews are closely related to the imposition of sanctions.

F. Center Responsibilities. The center shall cooperate in the review by:

1. promptly providing all necessary documents needed for review;

2. providing adequate space and privacy for the team to review records uninterrupted;

3. assisting with the identification and/or location of individual participants;

4. insuring that at least six months of current information is included in the active participant records, except that physician certification or recertification documents and interdisciplinary team assessments shall remain on file for the period of their currency;

5. arranging for pertinent personnel to attend the exit conference.

G. Inspection Team Responsibilities

1. Prior to the inspection, the team shall review:

a. all licensing surveys, Inspection of Care and UR reports from the previous calendar year;

b. all complaints about the center investigated during the previous calendar year.

2. The team shall compile a current list of all Title XIX recipients and applicants, including those for whom vendor payment to the center is not being made.

3. The team shall hold an entrance conference.

4. The social worker and RN shall each review the center record for each Title XIX participant. The team shall review at least the following items to assess the quality of care provided and to determine the need for continued stay:

a. medical, social, nursing and any other assessments which identify the needs of the participants;

b. the plan of care;

c. interdisciplinary progress notes;

d. physician orders;

e. the team shall review time and attendance records to insure that no participant was absent for a period of 30 or more calendar days without the center fulfilling its responsibilities to notify BHSF parish and BCSS regional offices. If the team finds that a participant was absent for a period of 30 or more calendar days and the center did not fulfill its responsibilities to notify BHSF parish and BCSS regional offices, the center will be cited.

f. any other center records which provide documentation of compliance with Louisiana State Medicaid Standards.

Example: administrative records may contain contracts and correspondence with the participant and/or responsible party.

5. Documentation reviewed by the inspection team shall provide evidence that:

a. interdisciplinary team assessments are complete and have been completed within the previous calendar year, except for social assessments which also shall have been updated at least quarterly;

b. the plan of care meets the requirements of 2313;

c. the plan of care is being implemented and all services ordered on the plan of care are being rendered and properly recorded in interdisciplinary progress notes;

d. the attending physician has written orders and has certified or recertified the need for either ICF I, II or SNF care within the previous calendar year;

e. interdisciplinary progress notes meet the requirements of 2315.

f. interdisciplinary progress notes describe the condition of the participant as observed by the inspection team;

g. the participant has made progress toward goals in the plan of care (otherwise, the plan of care is not viable);

h. at least 75 percent of the participant's scheduled services are among those services specified in 2501.D;

i. each participant has a current, adequate discharge plan;

j. the ID team has discharged its responsibilities;

k. the team shall determine if the center is in compliance with all requirements of this Subpart 3.

6. The social worker and RN shall interview each participant, the purpose of which shall be to:

a. document that the participant's condition is consistent with the description in the record;

b. determine whether the participant is receiving services to support maximum physical, mental and psychosocial functioning;

c. gather additional data, if needed, to make a level of care determination;

d. provide the participant the opportunity to make recommendations or complaints about the quality of care provided in the center.

7. One of the members of the team shall review incident reports compiled by the center during the previous calendar year, the purpose of which is to determine that the requirements of 2303.B have been met.

8. The team shall determine that each Title XIX recipient or applicant continues to meet the criteria specified in 2701.

9. If the team finds that the participant continues to meet those criteria, Form 51NH shall be issued assigning a review date, not to exceed 12 months from the date of the exit conference, for the current review.

10. If the team finds that a participant no longer meets the criteria specified in 2701, Form 142W shall be issued, no longer approving medical certification.

a. Item II.A. on Form 142W should be checked and completed as follows: "Medicaid payment will continue for above type services through the period of advance notice."

b. Advance notice of closure shall be sent by the parish office when the vendor payment is closed.

c. The center shall implement discharge of the participant during the effective period of the advance notice.

11. When a participant's record lacks sufficient or current data on which to base a determination, the center shall be cited in the Inspection of Care report.

12. The center shall be notified at the exit conference of the material necessary to make a medical ADHC eligibility determination and that if the requested materials are not received within 25 days, the participant shall be decertified.

a. Under no circumstances is an ADHC participant to remain certified for ICF or SNF for more than 30 days when medical eligibility has not been redetermined.

b. Advance notice of closure shall be sent when the case is closed by the parish office.

13. Prior to the exit conference, the team shall identify the areas in which the center was found deficient. This shall be based on:

a. a numerical compilation and analysis of the team's findings with regard to individual participants;

b. inspection of care and UR reports from the previous calendar year and the evidence of corrective action taken by the center with regard to those reports;

c. analysis of the center's incident reports and the complaints investigated in the center during the previous calendar year.

14. The team shall be prepared to provide at the exit conference the names of participants from whom immediate corrective action is indicated.

15. An exit conference shall be held to provide a verbal report of the team's findings.

a. This conference shall include at least the information required in 3101.H.2.j.

b. In addition, the team may also make professional recommendations to the center directed toward enhancing the quality of care provided. Such recommendations shall be clearly differentiated from deficiencies cited.

c. A center shall not be cited for a professional recommendation. However, a violation of professional practice standards constitutes a deficiency.

16. A review report of the team's findings shall be prepared whether or not any deficiencies were found or recommendations made.

17. Review reports shall contain all the information required by established DHH procedure and shall be submitted to the center within the time frames specified in that procedure. Copies shall be sent to the parties specified in the procedure.

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 11:629 (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 23:1158 (September 1997), LR 24:457 (March 1998), repromulgated LR 30:2051 (September 2004).

### **§3305. Discharge Planning and Implementation**

A. The purpose of discharge planning:

1. is to provide continuity of services for participants who may be temporarily absent from or permanently discharged from the center; and

2. serves to document the need for continued stay at the certified level of care.

B. The center shall maintain:

1. a current register of resources to support a lower level of care. This shall include, but not be limited to:

a. medical resources which address the needs of the community-based elderly/disabled population;

b. social resources which address the needs of this population;

c. financial resources which address the needs of this population;

d. any other supportive resource directed toward the community-based elderly/disabled population;

2. a current register of resources to support continued placement at the current level of care. This shall include, but not be limited to, medical/social/financial resources to support care at the ADHC level of care;

3. a current register of resources to support a more restrictive level of long term care. This shall include, but is not limited to, a current listing of:

a. Title XIX certified nursing homes within the community;

b. Title XVIII extended care facilities within the community;

c. any program which may further delay institutionalization;

4. a current register of medical/social acute care facilities which would meet the needs of participants who, because of acute medical problems, are temporarily unable to continue or achieve maximum potential in an ADHC center;

5. as part of an adequate discharge planning program, ensure continuity of services, prepare a discharge summary whenever a resource in Paragraphs 1, 2, 3 or 4 of this Subsection is required. This summary shall at least include:

a. medical diagnosis;

b. medication regimen (current physician orders);

c. treatment regimen (current physician orders);

d. functional needs (inabilities);

e. any special equipment (dentures, ambulatory aids, glasses, etc.);

f. social needs;

g. financial resources;

h. any other information which will enable the receiving agency/center to provide continued necessary care without interruption.

C. The discharge policy of the center shall include the provision that any Title XIX participant who does not attend as scheduled for 30 consecutive calendar days (hospitalization and documented illness excepted) shall be discharged.

D. Voluntary Transfer. When a participant transfers between ADHC Centers, the centers have the following responsibilities:

1. transferring center:

a. update plan of care;

b. complete Form 148W and forward to the BCSS regional and BHSF parish offices to notify of transfer;

c. send updated care plan and current physician orders to receiving center.

2. receiving center:

a. complete Form 148W and forward to the BCSS regional and BHSF parish offices to notify that participant has been accepted for placement;

b. assess and staff participant, and develop a new care plan within 14 days of actual attendance.

E. Involuntary Transfer or Discharge

1. Conditions of Transfer or Discharge. Involuntary transfer or discharge of a medical assistance participant may occur only under the following conditions:

a. for medical reasons;

b. for the participant's welfare or that of other participants; or

c. for nonpayment of the center fee.

2. Center Responsibilities. Center responsibilities in insuring an orderly transfer/discharge shall include the following tasks.

a. Plan of Care. The center shall complete a final update of the participant's individual plan of care with the transfer/discharge in mind.

b. Notice of Transfer/Discharge

i. The center shall complete the final update of the participant's individual plan of care and the transfer/discharge plan before submitting a written notice of transfer/discharge to the following individuals:

- (a). the participant;
- (b). the participant's responsible party;
- (c). the BHSF regional office;
- (d). the BHSF parish office.

ii. The written notice of transfer/discharge shall contain the following information:

- (a). the proposed date of the transfer/discharge and reason(s) for the same;
- (b). a discharge conference, date, time and place;
- (c). the personnel available to assist in locating an appropriate placement;
- (d). the participant's right for personal and/or third-party representation at all stages of the transfer/discharge process;
- (e). the participant's right to appeal with the DHH, Bureau of Appeals, within three days after the transfer/discharge conference.

iii. The written notice of transfer/discharge shall be submitted as soon as possible but at least three actual days of attendance prior to the transfer/discharge conference.

c. Transfer/Discharge Conference

i. The center director, the ID team, or a member of the ID team shall meet with the participant and responsible party to discuss the transfer/discharge. The discussion shall be conducted within the following time frames to insure an orderly transfer process:

- (a). as soon as possible in advance of the transfer/discharge; but
  - (b). at least 10 actual attendance days in advance.
- ii. The participant's presence at the conference may be waived with a written statement from the attending physician detailing the medical contraindications to the participant's participation in such a meeting.

iii. The participant and the responsible party shall be notified at least 72 hours in advance of the conference and shall be invited to attend and participate.

iv. Among those items discussed at this conference shall be those enumerated in Subparagraphs 2.a and b of this Subsection E.

F. Mass Transfer of Participants. The following provisions shall apply to any mass transfer.

1. Definition

*Mass Transfer* the intended relocation of more than 10 participants within a 30-day period.

2. Provider Enrollment Cancellation. When DHH determines that a center no longer meets state Title XIX requirements, the center's provider enrollment agreement is canceled.

3. Notice of Provider Enrollment Cancellation. On the date the center is notified that its provider agreement has

been canceled, DHH shall immediately begin notifying the participants, their responsible parties and other appropriate agencies or individuals of this action and of the service available to insure an orderly transfer and continuity of care.

4. Center Closing or Withdrawing from Title XIX Program. In situations where a center either voluntarily or involuntarily discontinues its operations or participation in the Medical Assistance Program, participants, their responsible parties and other appropriate agencies or individuals shall be notified as far in advance of the effective date as possible to insure them an orderly transfer and continuity of care.

a. If the center is closing its operations, plans shall be made for transfer.

b. If the center is voluntarily withdrawing from Title XIX participation, the participant has the option of remaining in the center on a private pay basis.

5. Payment Limitation. Payments may continue for Title XIX eligible recipients up to 30 days following the effective date the center's provider agreement is canceled.

a. The payment limitation also applies to Title XIX participants admitted prior to the cancellation of the agreement.

b. Payment is permitted only if the center totally cooperates in the orderly transfer of participants to other Title XIX centers or other placement arrangement of their choice.

Note: The center shall not admit new Title XIX recipients after receiving the notice that its agreement has been canceled. There shall be no payment approved for such admittance.

6. Coordination of Mass Transfer Activities

a. This process requires concentrated and prompt coordination among the following groups:

- i. the BCSS;
- ii. the parish office of the Bureau of Health Services Financing;
- iii. the center; and
- iv. other offices as designated by DHH.

b. This coordinated effort shall have the following objectives:

- i. protection of participants;
- ii. assistance to participants in finding the most appropriate placements when requested by them and/or their responsible parties; and
- iii. timely termination of vendor payment upon the participant's discharge from the center.

Note: The center still retains its usual responsibility during the transfer/discharge process to notify the parish Bureau of Health Services Financing promptly of all changes in the recipient's status.

7. Transfer Team

a. DHH shall designate certain staff members as a transfer team when a mass transfer of participants is necessary.

b. Their responsibilities shall include supervising transfer activities in the event cancellation of a provider agreement is proposed or in the event the center voluntarily terminates Title XIX participation.

c. The following steps and procedures shall be taken by or under the supervision of this team.

i. Step 1. Identification and Coordination. When a provider agreement is extended for up to 30 days beyond its original expiration date, the transfer team shall immediately perform the following tasks:

(a). identify appropriate receiving centers or facilities for the affected participants; and

(b). coordinate efforts with the BCSS regional office. The regional office has the responsibility to evaluate each participant's condition to make a determination about his/her appropriate level of care.

ii. Step 2. Supervision and Assistance. The transfer team shall take the following actions:

(a). supervise the center after cancellation of the agreement and during the transfer of its Title XIX participants;

(b). determine the last date for which vendor payment for a participant's care can be made;

(c). assist in making the most appropriate arrangements for the participants, providing the team member's names as contact persons if such help is needed.

iii. Step 3. Effecting the Transfer. In order to insure an orderly transfer/discharge, the transfer team shall also be responsible for performing the following tasks:

(a). meet with appropriate center administrative staff and other personnel as soon as possible after termination of a provider agreement to discuss the transfer planning process;

(b). continue to meet periodically with the center personnel throughout the transfer planning process;

(c). identify any potential problems;

(d). monitor the center's compliance with transfer procedures;

(e). resolve disputes in the participant's best interest;

(f). encourage the center to take an active role in the transfer planning;

(g). notify their superiors immediately of any lack of cooperation on the part of the center since this affects whether or not vendor payment will continue.

8. Provisions for Participant Services During Transfer/Discharge

a. DHH Responsibilities. DHH has the following responsibilities:

i. to provide social services necessary in the transfer/discharge plan or otherwise necessary to insure an orderly transfer/discharge in accordance with the Title XX State Plan; and

ii. to obtain other services available under Title XIX.

b. Participant Status Listing

i. At the conclusion of the 30-day period referred to in Paragraph 7 of this Subsection F, the transfer team shall submit a report to the BCSS state and BHSF parish offices, identifying the placement of each Title XIX participant who has been transferred to another Title XIX provider.

ii. If any participant has elected to end ADHC participation, this shall also be reported.

G. Emergency Situations

1. The center is responsible for immediately notifying BHSF, state and BCSS regional offices when a bona fide emergency exists, such as fire, contagious disease, or a severe threat to the participant's safety and well-being.

2. Each participant shall be immediately transferred or discharged from a center when a bona fide emergency exists, such as fire, contagious disease, or a severe threat to participant's safety and well-being.

3. Emergency transfers shall be closely reviewed and monitored by BCSS.

Note: Appropriate sanctions shall be imposed on centers which use emergency transfer provisions when no bona fide emergency exists.

4. Participant Rights. Nothing in the transfer/discharge plan shall interfere with existing participant rights.

5. Intelligent Waiver of Participant Rights

a. A participant may knowingly and intelligently waive any of the provisions of these regulations, provided the waiver is in writing.

b. The BCSS state office shall review all such waivers. The review shall insure that participants freely and intelligently waived their rights only after they and their responsible parties were fully informed of their rights under these transfer/discharge procedures.

Note: Appropriate sanctions shall be imposed on centers which obtain waivers by coercion or without providing full information about participant rights.

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 11:630 (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 23:1160 (September 1997), LR 24:457 (March 1998), repromulgated LR 30:2053 (September 2004).

## **Chapter 35. Appeals**

### **§3501. General Procedures**

A. Scope. DHH reserves the right to:

1. impose sanctions against any center;

2. reject any center's request for Title XIX participation; or

3. terminate any center's participation status under the conditions specified in 3901.B.1-5.

B. Informal Reconsideration

1. When a center receives a written adverse action, along with a copy of the findings upon which the decision was based, the center may notify the assistant secretary, BHSF, within 15 days of receiving the notification and request an informal reconsideration. The center may:

a. provide the assistant secretary with a letter and supporting documents, if applicable, to refute DHH's findings which result in the adverse action; or

b. present such findings which result in the adverse action; or

c. present such documentation at a meeting with the assistant secretary or his/her designee.

2. DHH shall review all documents submitted by the center and advise the center, in writing, prior to the effective date of the following actions:

a. that the original decision has been upheld; or

b. that the original decision has been reversed.

Note: The informal reconsideration decision is binding and the adverse action is not delayed by the center's request for an evidentiary hearing.

3. If the center receives written notification that the adverse action is being upheld, then the center may request an evidentiary hearing.

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 11:634 (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 23:1163 (September 1997), repromulgated LR 30:2055 (September 2004).

### **§3503. Evidentiary Hearing**

#### **A. General Requirements**

1. Any center which receives an adverse action from DHH may request an evidentiary hearing. Such a request shall be made to the secretary, DHH, within 30 days of receiving notification from DHH affirming the original adverse action based on the informal reconsideration.

2. The evidentiary hearing shall be conducted by DHH's Appeals Section which shall notify all interested parties of the time and place of the hearing.

3. Any party may appear and be heard at the proceeding through representation by an attorney-at-law or through a designated representative under the following conditions:

a. all persons appearing in proceedings before the Appeals Section shall conform to the standards of conduct practiced by attorneys before the courts of the state;

b. if a person does not conform to those standards, the hearing officer may decline to permit the person to appear in the proceedings.

4. Persons appearing in a representative capacity on behalf of the center shall file a written notice of appearance giving the following information:

- a. their names;
- b. their addresses;
- c. their telephone numbers;
- d. the party they represent; and
- e. a written authorization to appear on behalf of the center.

5. The Appeals Bureau shall notify the center, in writing, of the names and telephone numbers of DHH's representatives.

6. All papers filed in any proceeding shall:

- a. be typewritten;
- b. be signed by the party, authorized representative, or attorney;
- c. contain the address and telephone number of the party, authorized representative, or attorney; and
- d. be submitted to the Appeals Bureau including at least an original and two copies.

#### **B. Preliminary Conference**

1. Upon receiving a request for an evidentiary hearing, the Appeals Bureau must schedule a preliminary conference within 30 calendar days of receiving such a request or prior to the proposed termination date.

2. The purposes of the preliminary conferences shall include, but are not limited to:

- a. clarification, formulation, and simplification of issues;
- b. resolution of matters in controversy;
- c. exchange of documents and information;
- d. review of audit findings;
- e. reconsideration of any suspension or withholding of payments;
- f. stipulations of fact so as to avoid unnecessary introduction of evidence at the formal hearing;
- g. the identification of witnesses; and

h. such other matters as may aid disposition of the issues.

3. Preliminary Conference Notification. When the Appeals Bureau schedules a preliminary conference, it shall notify the center in writing. The notice shall direct any parties and their attorneys to appear at a specific date, time, and place.

#### **4. Conference Results**

a. When the preliminary conference resolves all or some matters in controversy, the Appeals Bureau shall submit a written summary of the following:

- i. the findings agreed to at the conference;
- ii. the results of the conference; and
- iii. a statement of further action required by the center or DHH.

b. When the preliminary conference does not resolve all matters in controversy, an evidentiary hearing shall be scheduled on those matters still in controversy. The hearing shall be scheduled within 30 calendar days following the completion of the preliminary conference.

#### **C. Evidentiary Hearing**

1. When an evidentiary hearing is scheduled, the Appeals Bureau shall notify the center and/or attorney, in writing, of the date, time, and place of the hearing.

2. The notice shall be mailed not less than 10 calendar days before the scheduled hearing date.

3. The Appeals Bureau shall also include a summary of the results of the preliminary conference.

4. The Appeals Bureau shall adhere to the following in regard to the evidentiary hearing.

a. The hearing shall be conducted by a hearing officer authorized to conduct such hearings.

b. Testimony shall be taken only on oath, affirmation, or penalty of perjury.

c. Each party shall have the right to:

- i. call and examine parties and witnesses;
- ii. introduce exhibits;
- iii. question opposing witnesses and parties on any matter relevant to the issue even though the matter was not covered in the direct examination;
- iv. impeach any witnesses regardless of which party first called them to testify; and
- v. rebut the evidence against witnesses.

d. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely on in the conduct of serious affairs. This evidence shall be admitted regardless of the existence of any common law or statutory rule which might make the admission of such evidence improper over objection in civil or criminal action.

e. The hearing officer may question any party or witness and may admit any relevant and material evidence.

f. The hearing officer shall control the admission of evidence in a manner best suited to ascertain the facts and safeguard the rights of the parties. Prior to taking evidence, the hearing officer shall explain the issues and the order in which evidence shall be received.

g. The burden of producing documentary evidence is on the party against whom the adverse action is being taken.

h. Parties shall arrange for the presence of their witnesses at the hearing:

i. a subpoena may be issued by the hearing officer upon written request by a party showing the need for the witness' presence;

ii. a subpoena to compel the attendance of a witness may be issued by the hearing officer on his/her own motion;

iii. an application for subpoena duces tecum for a witness to produce documents, papers, books, accounts, letters, photographs, objects, memoranda, other correspondence, records, or tangible items not privileged shall be made by affidavit to the hearing officer, giving the name and address of the person or entity upon whom the subpoena is to be served. It shall:

(a). describe the items which are desired to be produced and show the materiality of the evidence to the issue involved in the proceeding; and

(b). include a statement that, to the best of a person's knowledge, the witness has such items in his/her possession or under his/her control.

#### D. Amendments to Evidence

1. At any time prior to the completion of the hearing, amendments may be allowed on just and reasonable terms to:

a. add any party who should have been a part of the hearing process;

b. dismiss any party's evidence from the proceedings;

c. change the allegations or defenses; or

d. add new causes of action or defenses.

2. Where the agency seeks to add a party or give a cause of action or change in allegation, notice shall be given to the appropriate parties. Where a party other than DHH seeks to add a party or change defenses, notice shall be given in accordance with §3503.C.1-2. The hearing officer shall continue the hearing for such time as deemed appropriate, and notice of the new date shall be given.

#### 3. Continuance or Further Hearing

a. The hearing officer may continue a hearing to another time or place or order a further hearing under the following conditions:

i. on his/her own motion; or

ii. at the request of any party upon showing good cause.

b. When the hearing officer determines that additional evidence is necessary for the proper determination of the case, he/she may, at his/her discretion, do the following:

i. continue the hearing to a later date and order the party to produce additional evidence; or

ii. close the hearing and hold the record open in order to permit the introduction of additional documentary evidence. Any evidence so submitted shall be made available to both parties and each party shall have the opportunity for rebuttal.

c. Written notice of the time and place of a continued or further hearing shall be given.

Exception: When a continuance or further hearing is ordered during a hearing, oral notice of time and place of the hearing may be given to each party present.

E. Record of Proceedings. A complete record of the proceedings shall be made.

1. The testimony shall be transcribed and copies of other documentary evidence shall be reproduced when directed by the hearing officer.

2. The record shall also be transcribed and reproduced at the request of a party, provided the party pays for the cost of reproducing the transcript.

#### F. Failure to Appear

1. If a center representative fails to appear at a hearing, a decision may be issued by the Appeals Section dismissing the hearing.

2. A copy of the decision shall be mailed to each party together with a statement of the center's right to reopen the hearing.

3. Any dismissal may be rescinded if the center makes a written application to the hearing officer within 10 calendar days after the mailing of the decision, showing good cause for failure to appear at the hearing.

#### G. Timely Processing

1. The hearing shall be completed and a written decision rendered by the secretary, DHH, setting forth the reasons for the decision and the evidence upon which the decision is based within 30 calendar days of the conclusion of the hearing.

2. The decision of the secretary shall be final subject only to judicial review by the courts. Copies of the decision shall be mailed to the center at its last known address and to any representatives.

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 11:634 (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 23:1163 (September 1997), repromulgated LR 30:2056 (September 2004).

## Chapter 37. Audits

### §3701. Audits

A. All providers who elect to participate in the Title XIX Program shall be subject to audit.

1. A sufficient representative sample of providers will be fully audited to insure the fiscal integrity of the program and compliance of providers with program regulations governing reimbursement.

2. Limited scope and exception audits shall be conducted as required.

B. In addition to routine audits related to fiscal accountability, audits may also be conducted at the time of change of ownership, voluntary or involuntary closure of a center, or investigation of complaints against a center.

C. Each center shall submit a cost report to Bureau of Health Services Financing within 90 days of the end of its accounting period or fiscal year end.

D. Instructions for cost reporting and the form to be used are provided in the provider enrollment packet.

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 11:636 (June 1985), amended LR 13 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary,

Bureau of Health Services Financing, LR 23:1165 (September 1997), repromulgated LR 30:2057 (September 2004).

## **Chapter 39. Sanctions**

### **§3901. Compliance with Standards for Participation**

A. A center may be found to be out of compliance with this Subpart 3 as a result of the following activities:

1. field or desk audits;
2. utilization reviews;
3. inspection of care;
4. complaint investigations;
5. licensing surveys;
6. federal reviews or assessments;
7. Attorney General's Medicaid Fraud Control Unit investigations;

8. Surveillance and Utilization Reviews (SURs).

B. DHH reserves the right to impose interim sanctions, to reject any center's request for Title XIX participation, or to terminate any center's participation when there is documentation that the center:

1. fails to abide by the rules promulgated for the ADHC Program by the BHSF or any other state or federal agency;
2. is not in compliance with Title VI of the Civil Rights Act;
3. engages in practices not in the best interests of any medical assistance recipient;
4. fails to achieve and maintain substantial compliance with this Subpart 3. It shall be the decision of the secretary of DHH to refuse or terminate enrollment for this reason;
5. has previously been sanctioned.

#### **C. Interim Sanctions**

1. DHH may impose sanctions if a center is found to be not in compliance with this Subpart 3, or licensing regulations for adult day health care centers.

2. These sanctions are directly related to:

- a. the severity of the conditions found in the center which adversely affect or potentially affect the safety, rights, health and well-being of the participants;
- b. the degree of fiscal integrity with which the center is administered;
- c. compliance with this Subpart 3.

3. Health, Safety and Personal Rights Violations Sanctions

a. Sanctions for health, safety and personal rights violations include:

- i. restricted Title XIX certification for new admissions;
- ii. fiscal sanctions;
- iii. withholding of vendor payment;
- iv. provisional licensure.

b. Provisional Licensure Status

i. The center's license may be placed in provisional status for a period not to exceed 90 days.

ii. If there is no documentation of immediate improvement in the conditions which affect the life, safety or welfare of the participants, the license shall be revoked.

#### **4. Sanctions for Administrative Violations**

a. Sanctions for administrative violations include:

- i. fiscal sanctions;
- ii. withholding of vendor payment;
- iii. provisional licensure.

b. Provisional Licensure Status

i. The center's license may be placed in provisional status for a period not to exceed 90 days.

ii. If there is no documentation of immediate improvement in the conditions which affect the life, safety or welfare of the participants, the license shall be revoked.

D. Appeals Procedure. See 3501 which describes the appeal procedure a center may use when adverse action has been taken against it by DHH.

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 11:636 (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 23:1166 (September 1997), repromulgated LR 30:2058 (September 2004).

Frederick P. Cerise, M.D., M.P.H.  
Secretary

0409#031

### **RULE**

#### **Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing**

##### **Hospital Program Outpatient Surgery Services HIPAA Implementation**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgates the following Rule 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.

#### **Rule**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the rules governing the billing and reimbursement of all outpatient hospital surgery services. Current Standard Healthcare Common Procedure Coding System (HCPCS) codes and modifiers shall be used to bill for all outpatient hospital surgery services. Medicaid payment rates shall be established and assigned to each code based on the Medicare payment rates for outpatient surgery services.

Frederick P. Cerise, M.D., M.P.H.  
Secretary

0409#039

first-time mother continues to be the focus of the NFP Program after the birth of the child (*Louisiana Register*, Volume 32, Number 7). This Emergency Rule is being promulgated to continue the provisions of the July 20, 2006 Emergency Rule. This action is being taken to avoid federal sanctions.

Effective March 19, 2007, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the provisions of the August 20, 2005 Rule addressing the program description and recipient qualifications in the Nurse Family Partnership Program.

**Title 50**

**PUBLIC HEALTH—MEDICAL ASSISTANCE**

**Part XV. Services for Special Populations**

**Subpart 7. Targeted Case Management**

**Chapter 111. Nurse Family Partnership Program**

**§11101. Introduction**

A. Nurse Family Partnership (NFP) targeted case management is a prenatal program designed to improve the health and social functioning of Medicaid eligible first-time mothers and their babies.

B. ...

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 Community Supports and Services LR 30:1041 (May 2004), amended LR 31:2028 (August 2005), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 33:

**§11103. Recipient Qualifications**

A. A Medicaid recipient must not be beyond the twenty-eighth week of pregnancy and must attest that she meets one of the following definitions of a first-time mother in order to receive NFP case management services. The recipient:

A.1. - B.3. ...

C. Nurse Family Partnership case management services to the mother may continue up to two years after the birth of the 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 Community Supports and Services LR 30:1041 (May 2004), amended LR 31:2028 (August 2005), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 33:

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

Interested persons may submit written comments to Jerry Phillips, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, Louisiana 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Frederick P. Cerise, M.D., M.P.H.  
Secretary

0702#065

**DECLARATION OF EMERGENCY**

**Department of Health and Hospitals  
Office of the Secretary  
Office of Aging and Adult Services**

Home and Community-Based Services Waiver  
Adult Day Health Care  
Direct Service Professionals Wage Enhancement  
(LAC 50:XXI.3109)

The Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services amends LAC 50:XXI.3109 under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services adopted provisions governing the reimbursement methodology for the Adult Day Health Care (ADHC) Waiver (*Louisiana Register*, Volume 30, Number 9). This Emergency Rule is being promulgated to amend the provisions of the September 20, 2004 Rule governing the reimbursement methodology for the ADHC Waiver by increasing reimbursement to providers to implement a wage enhancement for direct care staff. It is the intent that the wage enhancement be paid to the direct care staff.

This action is being taken to promote the health and well-being of waiver recipients by assuring continued access to services through assisting providers to recruit and retain sufficient direct care staff. It is estimated that implementation of this Emergency Rule will increase expenditures in the ADHC Waiver Program by approximately \$42,356 for state fiscal year 2006-2007.

Effective February 9, 2007, the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services amends the provisions governing the reimbursement methodology for the Adult Day Health Care Waiver by increasing reimbursement to providers to implement a wage pass-through payment for direct care workers.

**Title 50**

**PUBLIC HEALTH—MEDICAL ASSISTANCE**

**Part XXI. Home and Community Based Services**

**Waivers**

**Subpart 3. Adult Day Health Care**

**Chapter 31. Reimbursement**

**Subchapter A. Prospective Payment System**

**§3109. Provider Reimbursement**

A. - B.7.a. ...

i. For dates of service on or after February 9, 2007, the facility-specific direct care price will be increased by \$1.11 to include a direct care service worker wage enhancement. It is the intent that this wage enhancement be paid to the direct care service workers.

B.7.b. - B.8.b ...

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 30:2048 (September 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 33:

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

Interested persons may submit written comments to Hugh Eley, Office of Aging and Adult Services, P.O. Box 2031, Baton Rouge, LA 70821-2031. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Frederick P. Cerise, M.D., M.P.H.  
Secretary

0702#027

**DECLARATION OF EMERGENCY**

**Department of Health and Hospitals  
Office of the Secretary  
Office for Citizens with Developmental Disabilities**

Home and Community-Based Services Waivers  
Children's Choice  
Direct Support Professionals Wage Pass-Through  
(LAC 50:XXI.12101)

The Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities amends LAC 50:XXI.12101 under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted provisions governing the reimbursement methodology for the Children's Choice Waiver (*Louisiana Register*, Volume 28, Number 9). The Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities is promulgating this Emergency Rule to amend the provisions of the September 20, 2004 Rule governing the reimbursement methodology for the Children's Choice Waiver to implement an hourly wage pass-through payment to providers for direct care staff.

This action is being taken to promote the health and well-being of waiver recipients by assuring continued access to services through assisting providers to recruit and retain sufficient direct care staff. It is estimated that implementation of this Emergency Rule will increase expenditures in the Children's Choice Waiver Program by approximately \$334,222 for state fiscal year 2006-2007.

Effective February 9, 2007, the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with

Developmental Disabilities amends the provisions governing the reimbursement methodology for the Children's Choice Waiver to implement a wage pass-through payment to providers for direct support professionals.

**Title 50**

**PUBLIC HEALTH—MEDICAL ASSISTANCE  
Part XXI. Home and Community-Based Services**

**Waivers**

**Subpart 9. Children's Choice**

**Chapter 121. Reimbursement**

**§12101. Reimbursement Methodology**

A. - B.4. ...

**5. Direct Support Professionals Wage Pass-Through.**

a. Effective February 9, 2007, an hourly wage pass-through payment in the amount of \$2 will be reimbursed to providers for full-time equivalent (FTE) direct support professionals who provide Family Support Services to Medicaid home and community-based waiver services recipients.

i. At least 75 percent of the wage pass-through shall be paid to personal care workers as wages. If less than 100 percent of the pass-through is paid in wages, the remainder, up to 25 percent shall be used to pay employer-related taxes, insurance and employee benefits.

ii. The minimum hourly rate paid to direct support professionals shall be the current minimum wage plus 75 percent of the wage pass through.

b. Providers shall be required to submit a certified wage register to the department verifying the direct support professionals' gross wages for the quarter ending June 30, 2005. The wage register will be used to establish a payroll baseline for each provider. It shall include the following information:

i. gross wage paid to the direct support professional(s);

ii. total number of direct support hours worked; and

iii. the amount paid in employee benefits.

c. A separate report shall be submitted for paid overtime.

d. The provider shall submit quarterly wage reports that verify that the 75 percent wage pass-through has been paid to the appropriate staff.

e. The provider shall submit a report, according to the department's specifications, that will be used to measure the effectiveness of the wage pass-through.

f. Audit procedures shall be established by the department to verify the wage-pass through payments reimbursed to providers.

g. Noncompliance or failure to demonstrate that the wage pass-through was paid directly to direct support professionals may result in:

i. forfeiture of eligibility for wage pass-through payments;

ii. recoupment of previous wage pass-through payments;

iii. Medicaid fraud charges; and

iv. loss of provider license.

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

5. A separate report shall be submitted for paid overtime.

6. The provider shall submit quarterly wage reports that verify that the 75 percent wage enhancement has been paid to the appropriate staff.

7. The provider shall submit a report, according to the department's specifications, that will be used to measure the effectiveness of the wage enhancement.

8. The wage enhancement payments reimbursed to providers shall be subject to audit by the department.

9. Noncompliance or failure to demonstrate that the wage enhancement was paid directly to direct support professionals may result in:

a. forfeiture of eligibility for wage enhancement payments;

b. recoupment of previous wage enhancement payments;

c. Medicaid fraud charges; and

d. disenrollment from the Medicaid Program.

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, Office for Citizens with Developmental Disabilities, LR 32:1607 (September 2006), amended LR 33:

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

Interested persons may submit written comments to Kathy Kliebert, Office for Citizens with Developmental Disabilities, P.O. Box 3117, Baton Rouge, LA 70821-3117. She is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Frederick P. Cerise, M.D., M.P.H.  
Secretary

0705#089

## DECLARATION OF EMERGENCY

**Department of Health and Hospitals  
Office of the Secretary  
Office of Aging and Adult Services**

Home and Community Based Services Waivers  
Adult Day Health Care  
(LAC 50:XXI.Chapters 21, 23, and 27)

The Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services proposes to amend LAC 50:XXI.2101, 2103, 2107, 2109, 2313 and Chapter 27, and to adopt §2317 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted provisions governing home and community-based waiver

services for adult day health care (*Louisiana Register*, Volume 30, Number 9). The Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services amended the provisions governing the Adult Day Health Care (ADHC) Waiver Request for Services Registry to: 1) clarify procedures for the allocation of ADHC waiver opportunities; 2) amend the provisions governing the medical certification process to remove preadmission screening and annual resident review requirements; and 3) eliminate the use of the Title XIX Medical-Social Information Form (Form 90-L) (*Louisiana Register*, Volume 32, Number 12). The department promulgated an Emergency Rule to amend the September 20, 2004 Rule to: 1) redefine the target population; 2) establish provisions governing placement on the request for services registry; 3) clarify the comprehensive plan of care requirements; and 4) establish provider reporting requirements and admission and discharge criteria for the ADHC Waiver (*Louisiana Register*, Volume 33, Number 3). The department now proposes to amend the September 20, 2004 Rule to more precisely define the target population, establish explicit provisions governing placement on the request for services registry and admission and discharge criteria for the ADHC Waiver.

This action is being taken to avoid federal sanctions which may result from not having provisions to clearly define the ADHC target population and admission and discharge criteria. It is anticipated that implementation of this Emergency Rule will not have a fiscal impact in the Medicaid Program for state fiscal year 2006-2007.

Effective May 20, 2007, the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services amends the provisions of the September 20, 2004 Rule governing the Adult Day Health Care Waiver program.

### Title 50

## **PUBLIC HEALTH—MEDICAL ASSISTANCE Part XXI. Home and Community Based Services Waivers**

### **Subpart 3. Adult Day Health Care**

#### **Chapter 21. General Provisions**

##### **§2101. Introduction**

A. These standards for participation specify the requirements of the Adult Day Health Care (ADHC) Waiver Program. The program is funded as a waiver service under the provisions of Title XIX of the Social Security Act and is administered by the Department of Health and Hospitals (DHH).

B. Waiver services are provided under the provisions of the approved waiver agreement between the Centers for Medicare and Medicaid Services (CMS) and the Louisiana Medicaid Program.

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 30:2034 (September 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 33:

##### **§2103. Program Description**

A. An Adult Day Health Care (ADHC) Waiver program provides direct care for five or more hours in a 24-hour weekday to individuals who are physically and/or mentally impaired.

B. The target population for the ADHC Waiver Program is individuals who meet Medicaid financial eligibility requirements and nursing facility level of care requirements, and who are either receiving Medicaid-funded services in a nursing facility or at imminent risk of nursing facility placement.

1. A person is considered to be at imminent risk of nursing facility placement when he:

- a. is likely to require admission to a nursing facility within the next 120 days;
- b. faces a substantial possibility of deterioration in mental condition, physical condition or functioning if either home and community-based services or nursing facility services are not provided in within 120 days; or
- c. has a primary caregiver who has a disability or is over the age of 70.

2. These individuals must be 65 years old or older, or 22 to 64 years old and disabled according to Medicaid standards or the Social Security Administration's disability criteria.

C. This program expands the array of services available to functionally-impaired individuals and helps bridge the gap between independence and institutional care, allowing them to remain in their own homes and communities.

D. Goals

1. Adult Day Health Care programs work to:
  - a. promote the individual's maximum level of independence;
  - b. maintain the individual's present level of functioning as long as possible, preventing or delaying further deterioration;
  - c. restore and rehabilitate the individual to the highest possible level of functioning;
  - d. provide support and education for families and other caregivers;
  - e. foster socialization and peer interaction; and
  - f. serve as an integral part of the community services network and the long-term care continuum of services.

2. The long-range goal for all adult day health care participants is the delay or prevention of 24-hour care.

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 30:2034 (September 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 33:

**§2107. Request for Services Registry**

A. The Department of Health and Hospitals is responsible for the Request for Services Registry, hereafter referred to as "the registry," for the Adult Day Health Care Waiver. An individual who wishes to have his or her name placed on the registry shall contact a toll-free telephone number which shall be maintained by the department.

B. Individuals who desire their name to be placed on the ADHC Waiver registry shall be screened to determine whether they meet nursing facility level of care and are at imminent risk of nursing facility placement. Only individuals who meet these criteria will be added to the registry.

C. Individuals currently on the ADHC Waiver registry will be screened to determine whether they meet nursing

facility level of care and are at imminent risk of nursing facility placement.

D. An individual who does not meet the criteria for placement on the registry may appeal the decision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and pursuant to 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 30:2035 (September 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 32:2256 (December 2006), LR 33:

**§2109. Programmatic Allocation of Waiver Opportunities**

A. When funding is appropriated for a new ADHC Waiver opportunity or an existing opportunity is vacated, the department shall send a written notice to an individual on the registry indicating that a waiver opportunity is available. That individual shall be evaluated for a possible ADHC Waiver opportunity assignment.

B. Adult Day Health Care Waiver opportunities shall be offered based upon the date of first request for services, with priority given to individuals who are in nursing facilities but could return to their home if ADHC Waiver services are provided. Priority shall also be given to those individuals who are at imminent risk of nursing facility placement.

1. Remaining waiver opportunities, if any, shall be offered on a first-come, first-serve basis to individuals who qualify for nursing facility level of care, but who are not at imminent risk of nursing facility placement.

C. If an applicant is determined to be ineligible for any reason, the next individual on the registry is notified and the process continues until an individual is determined eligible. An ADHC Waiver opportunity is assigned to an individual when eligibility is established and the individual is certified.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 33:

**Chapter 23. Provider Participation**

**§2313. Comprehensive Plan of Care (CPOC)**

A. ...

B. Reimbursement shall not be made for ADHC Waiver services provided prior to the department's approval of the CPOC. Comprehensive plans of care must be completed and submitted timely in accordance with DHH policy and procedures.

C. The ADHC provider shall complete a CPOC which shall contain the type and number of services, including waiver and all other services, necessary to maintain the waiver recipient safely in the community.

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 30:2040 (September 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 33:

**§2317. Reporting Requirements**

A. ADHC facilities are obligated to report changes to the department that could affect the waiver recipient's eligibility including, but not limited to, those changes cited in the denial or discharge criteria.

B. ADHC facilities are responsible for documenting the occurrence of incidents or accidents that affect the health, safety and welfare of the recipient and completing an incident report. The incident report shall be submitted to the department with the specified requirements.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 33:

## **Chapter 27. Admission and Discharge Criteria**

### **§2701. Admission Criteria**

A. Admission to the ADHC Waiver Program shall be determined in accordance with the following criteria:

1. initial and continued Medicaid financial eligibility;
2. initial and continued eligibility for a nursing facility level of care;
3. justification, as documented in the approved CPOC, that the ADHC Waiver services are appropriate, cost-effective and represent the least restrictive environment for the individual;
4. assurance that the health, safety and welfare of the individual can be maintained in the community with the provision of ADHC Waiver services; and
5. the individual is either in a nursing facility or is at imminent risk of nursing facility placement.

B. Failure of the individual to cooperate in the eligibility determination process or to meet any of the criteria in §2701.A. above will result in denial of admission to the ADHC Waiver.

C. - 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 Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2041 (September 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 33:

### **§2703. Discharge Criteria**

A. The recipient shall be discharged from the ADHC Waiver Program if any of the following conditions are determined.

1. The individual does not meet the criteria for Medicaid financial eligibility.
2. The individual does not meet the criteria for a nursing facility level of care.
3. The recipient resides in another state or has a change of residence to another state.
4. The individual is admitted to an acute care hospital, rehabilitation hospital or a nursing facility with the intent to stay, or a stay that is longer than 90 consecutive days.
5. Continuity of services is interrupted as a result of the recipient not receiving and/or refusing ADHC Waiver services during a period of 30 consecutive days.
6. The health, safety and welfare of the individual cannot be assured through the provision of ADHC Waiver services.
7. The individual fails to cooperate in the eligibility determination process or in the performance of the CPOC.
8. It is not cost effective to serve the individual in the ADHC Waiver.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 33:

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

Interested persons may submit written comments to Hugh Eley, Office of Aging and Adult Services, P.O. Box 2031, Baton Rouge, LA 70821-2031. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Frederick P. Cerise, M.D., M.P.H.  
Secretary

0705#085

## **DECLARATION OF EMERGENCY**

### **Department of Health and Hospitals Office of the Secretary Office of Aging and Adult Services**

Home and Community Based Services Waivers  
Elderly and Disabled Adult Waiver  
(LAC 50:XXI.Chapters 81 and 85)

The Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services proposes to amend LAC 50:XXI.Chapters 81 and 85 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing adopted provisions governing home and community-based waiver services for elderly and disabled adults in LAC 50:XXI.Chapters 81-89 (*Louisiana Register*, Volume 30, Number 8). The Division of Long Term Supports and Services amended the provisions governing the Elderly and Disabled Adult (EDA) Waiver to: 1) eliminate the duplication of like services currently provided in the waiver and as a Medicaid State Plan service; 2) define the existing service package and establish new services; and 3) revise the methodology for allocation of waiver opportunities (*Louisiana Register*, Volume 32, Number 7). The department promulgated an Emergency Rule to amend the August 20, 2004 Rule to establish provisions governing placement on the request for services registry (*Louisiana Register*, Volume 33, Number 3). The department now proposes to amend the August 20, 2004 Rule to further clarify the provisions governing the EDA Waiver, including the provisions governing placement on the request for services registry, allocation of waiver opportunities and admission and discharge criteria.

This action is being taken to promote the well-being of Louisiana citizens by facilitating access to home and community-based services through the adoption of clear and precise provisions for the EDA Waiver request for services

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3.4 Other Policies and Procedures

1. Accounting records must be kept (or converted at year end) on an accrual basis.
2. Each facility must maintain all accounting records, books, invoices, cancelled checks, payroll records, and other documents relative to client care costs for a period of six years.
3. All fiscal and other records pertaining to client care costs shall be subject at all times to inspection and audit by the Department of Health and Human Resources, the Legislative Auditor, and auditors of appropriate Federal funding agencies.
4. Each facility must maintain statistical information related to the daily census and/or attendance records for all clients receiving care in the facility.
5. Each facility receiving funds from other public sources must note such on the cost report form, even if the funding is provided for other programs, and make available additional information on this funding as requested by DHHR.

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6. Purchase discounts, allowances, and refunds will be recorded as a reduction of the cost to which they relate.
7. The availability of State and Federal funds may result in a recomputation of rates in accordance with departmental policy and procedures.
8. Payment procedures do not include a year-end settlement. Rates determined in accordance with this manual are prospective in nature. The Department however will pursue recoupment in the event of an overpayment resulting from an error in setting the rate.

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3.5 Submission of Cost Reports and Budgets

A. General Instructions

1. Cost reports will be filed by each provider according to the following schedule:

Due Date

9/30

Information Required

Cost report covering twelve months ending 6/30 plus budget covering twelve months 7/1 through 6/30. The provider submits the following forms and schedules:

- . Cost Report and Budget Form
- . Schedule A-1, Balance Sheet-Assets
- . Schedule A-2, Balance Sheet-Liabilities
- . Schedule B, Income Statement
- . Schedule C-1, Basic Support Cost
- . Schedule C-2, Programmatic Cost
- . Schedule C-3, Explanations of Adjustments
- . Schedule C-4, Cost Category Totals
- . Schedule D, Depreciation

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Due Date

Information Required

- . Schedule E-1, In-Kind Contributions- Cost Report
  - . Schedule E-2, In-Kind Contributions-Budgeted
  - . Schedule F, Certification Statement
2. The provider contract contains a penalty provision for cost reports and budgets with all forms completed, not received on a timely basis. A penalty of 5% of the total monthly payment for the first month and a progressive penalty of 5% of the total monthly payment for each succeeding month may be imposed for non-compliance.
  3. All cost report information will be submitted in accordance with generally accepted accounting principles as well as state and federal regulations. The accrual method of accounting is the only acceptable method for private providers. State institutions will be allowed to submit data on the cash basis.
  4. The attached cost report and budget forms will be used by all providers for Title XIX and other facilities receiving State funds. All providers will use the same cost determination methods prescribed in this section.
  5. All providers who participate will maintain, for six years following submission of the cost report, all financial and statistical information necessary to substantiate cost data. All providers are required to make these records available upon request to representatives of the State DHHR or Federal DHHS.

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3. All cost report information will be submitted in accordance with generally accepted accounting principles as well as state and federal regulations. The accrual method of accounting is the only acceptable method for private providers. State institutions will be allowed to submit data on the cash basis.
  
4. The requirement for submission of cost reports every 6 months will be reviewed by the Rate Setting Policy Committee in December, 1984 to determine if data gathered for these cost reports warrants continuation of the requirement.

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6. For the purposes of rate setting, only the straight-line method of depreciation will be allowed. Depreciation expense may be reported as a total annual amount on either cost report submitted.
7. The data submitted on the cost report will reflect Balance Sheet and Operating Statement information for the twelve month period being submitted. Cost data will be appropriately adjusted (as described elsewhere in this manual) for rate setting purposes. These reports should be submitted to:

Rate Administrator  
Department of Health and Human Resources  
P. O. Box 3776  
Baton Rouge, LA 70821

For Title XIX funded facilities, the Rate Administrator will make a copy of cost data available to the Office of Family Security. If providers need assistance or an extension of time for filing cost reports and budgets, they should contact the Rate Administrator.

8. All costs submitted on cost reports and budgets must be resident care related. A knowing inclusion of costs in violation of this requirement, as well as other requirements of HIM-15, could subject the provider to criminal prosecution under La. R. S. 14:70.1 or La. R. S. 14:133.
9. For allocated or shared costs, separate cost report and budget forms must be completed showing the total costs prior to allocation. The method of allocation and the percentage of allocation to each individual provider must also be shown. If there are costs included in a provider's budget from several organizational layers, a separate set of cost report and budget forms must be included for each layer.

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B. Instructions for Cost Report and Budget Form

Item A - Type of Facility - Check appropriate block and indicate Title XIX vendor and/or FADS number.

Item B - Type of Control - Check appropriate block.

Item C - Level of Care - To be determined at a later date.

Item D - Statistical Data:

1. Enter total number of beds available for use at beginning of period.
2. Enter total number of beds available for use at end of period.
3. Indicate the effective date if licensed capacity changed during the period.
4. Enter the total bed days available during the period.
5. Enter actual days of care rendered to clients in each category, and in total. Count day of admission but not day of discharge. Day of death may be included.

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6. Enter the percent of occupancy (line 5 divided by line 4).
7. Enter total number of clients in facility at beginning of reporting period.
8. Enter total number of clients admitted for care during period.
9. Enter the total number of clients discharged, including deaths, for the reporting period.
10. Enter total number of patients in facility at end of reporting period (line 7 plus line 8 minus line 9).

Item E - Ownership and Related Organizations

1. List all owners with 5% interest or more (even if they receive no compensation) and close relatives employed by owners. For this purpose, close relatives of owners include spouse, parents, grandparents, brothers, sisters, children, and in-laws including parents, grandparents, brothers and sisters of owner's spouse. For additional information, refer to HIM 15.

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For close relatives of owners, indicate the relationship.

For each person listed, indicate the function performed in the facility (title), percentage of work week devoted to this business, percent of ownership, and compensation included in allowable cost for the cost report period.

A reasonable allowance of compensation for services of owners is an allowable cost, provided the services are actually performed in a necessary function.

- a. Compensation - means the total benefit received by an owner for services rendered to an institution including salary, personal benefits, management fees, consulting fees, bonuses, costs of goods and services an owner receives from a facility and deferred compensation.
- b. Reasonable - an amount as would ordinarily be paid for comparable services by comparable facilities.

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- c. Necessary - pertinent to the operation of the facility and, had the owner not rendered the service, the facility would have had to employ another person to do so at a comparable cost.
2. Under type of change, enter whether change is in ownership, licensure or certification. Indicate the nature of the change, for example - From: 100 beds To: 150 beds, and date of change.
  3. If facility is rented or leased, enter name of owner of leased assets, relationship to operator of facility and terms of lease. Attach a copy of the executed lease agreement effective during the period of this report.
  4. Indicate if costs are included in this cost report or budget which result from transactions with related organizations.
- .A related organization is defined as an organization related to the provider by common ownership or control.
- .Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and organization serving the facility.

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.Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or facility.

If such costs are included, enter the information requested in items 4. a. and b. Cost applicable to services, facilities, and supplies furnished to the facility by related organizations are allowable costs at the cost to the related organization. However, such costs must not exceed the price of comparables purchased in the open market and the goods and services must be common to and generally purchased by client care facilities.

Item F - Staff and Other Information

1. Enter the total number of employees for the last payroll of the cost report period.
2. Enter the number of full time equivalent positions by category. In the Cost Report Period column, enter the actual number of full time equivalent positions, including those that are vacant, at the end of the Cost Report period. In the Budget Period column, enter the total full time equivalent positions planned as of the end of the Budget period.
- 3.-6. See form for instructions.

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Item G - Budgeted Staff Positions

Enter the position title of each budgeted position. If vacant at beginning of the budget period, enter anticipated date of hire. Enter the average hours per week employed. In the annual salary column, enter the total salary for each position included in the budget. The amounts on this form must balance with the salary amounts on Forms C-1 and C-2. A column has been added for identification of the line item on Forms C-1 and C-2 on which the salary amounts are found. If additional space is required, the provider should attach additional schedules.

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C. Instructions for Balance Sheet (Schedules A-1 and A-2)

1. On Schedule A-1, enter appropriate balance sheet asset accounts per books as of the end of the cost report period.
2. On Schedule A-2, enter appropriate balance sheet liability and equity accounts per books for the cost report period.
3. Pro forma balance sheets, projected for the budget period, are not required.

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D. Instructions for Income Statement (Schedule B)

1. In the Cost Report Period column, enter appropriate income account balances per books as of the end of the period. In the Budget Period column, enter total projected income.
  
2. For Federal or State grant income, indicate the type of grant and period covered. If the grant is continuous or declining, state future percentages or amounts. If more than one grant, list each one separately. Attach additional pages as required. Applications for Federal or State grants must be detailed on attachments. The information submitted should include:
  - 1) Type of grant
  - 2) Date of application
  - 3) Period covered and items requested
  - 4) Anticipated notification date
  
3. For Refunds and Allowances, indicate the amount reimbursed or credited to DHHR, if any, the amount credited to personal accounts of clients, etc.

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E. Instructions for Basic Support and Programmatic Cost  
(Schedules C-1 and C-2)

1. General Format

- Column (a) - Enter total expenses for the cost report period from the General Ledger.
- Column (b) - Enter adjustments to total expenses per books for the cost report period.
- Column (c) - Enter net allowable expenses for the cost report period : Column (a) plus or minus adjustments in Column (b).
- Column (d) - Enter total budgeted expenses, net of any anticipated adjustments, for the budget period.

2. Adjustments

The following guidelines are provided to aid in determining allowable and non-allowable costs for rate setting and reporting purposes. Allowable costs generally require no adjustment when reported. Non-allowable costs should be reflected as such by an adjustment to the proper cost category on the schedule.

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a. Personnel and Salary Maximums

Salaries are an allowable cost if:

- (1) The number of employees is based upon individual facility requirements determined in conjunction with DHHR Licensing and Certification and the appropriate program office, and
- (2) Functions performed are related to the provision of care in the facility, and
- (3) Individual salaries do not exceed the maximum allowable under Louisiana State Civil Service Salary Schedules for comparable positions. State salaries for this purpose include related benefits.

Positions requested in the budget, both existing and proposed, may be eliminated as non-allowable costs, if the review in (1) above reveals that they are not needed. No position however may be eliminated if it is needed to maintain compliance with licensing or Title XIX requirements or to correct licensing or Title XIX deficiencies as determined in (1) above. Need for a position will be determined after consultation with the facility and must be related to approved programs at the facility.

b. Taxes

With the following specific exceptions, taxes are an allowable cost.

- .Federal income or excess profit tax
- .State income or excess profit tax
- .Taxes relating to financing
- .Special assessments (This would be capitalized and amortized.)
- .Taxes for which exemptions are available
- .Taxes on property not related to direct client care
- .Self-employment (FICA) taxes applicable to individual proprietors, partners, etc.

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c. Advertising

Cost for the following types of advertising are allowable:

- .Classified newspaper advertising to recruit personnel or solicit bids.
- .Telephone "Yellow Page" advertising, except in the event that such advertisement is promotional in nature. Allowable cost is limited to the cost of a 1" x 1" size ad.

Costs for fund raising, public relations and promotional advertising are income producing items which should be offset against income provided.

d. Bad Debts

Bad debts, charity and courtesy allowances are deductions from revenue and are not an allowable cost.

e. Dues

Dues are not an allowable expense.

f. Interest Expense

Generally, necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) "Necessary" requires that interest:

- .be incurred on a loan made to satisfy a financial need of the provider
- .be incurred on a loan reasonably related to patient care
- .be reduced by investment income

(2) "Proper" requires that interest:

- .be incurred at a rate not in excess of what a prudent borrower would have to pay
- .be paid to a lender not related through control or ownership or personal relationship to the provider. Exceptions are allowable only in accordance with HIM-15, paragraph 218.

g. Attorneys' Fees

Only actual and reasonable attorney fees incurred for nonlitigation legal services which are directly related to client care will be allowed.

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2. Exception to the Inflation Screen Percentage

An exception to the inflation screen percentage set by the Rate Setting Policy Committee can be granted under the following circumstances:

- . A program office negotiates with an ongoing provider for new programs and services needed for its clients or for licensed capacity reductions; and
- . The program office recommends an exception to the inflation screen percentage. The amount of the exception should correspond to the incremental costs of the change; and
- . The inflation screen exception request is approved by the Rate Setting Policy Committee; and
- . The exception is within Title XIX guidelines for Title XI funded facilities; and
- . The methodology utilized for calculating the amount of exception will involve calculation of the percentage increase in the budget caused by the exception and adding that percentage to the base inflation screen.

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- .Periodic medical examinations that include vision, hearing, and routine screening and laboratory examinations as determined necessary by the physician.
- .Immunization
- .Tuberculosis control
- .Physician services, minimally to supervise the general health conditions and practices of the facility and be available for emergencies on a 24-hour, seven-days-a-week basis
- .Initial and periodic dental examinations and routine treatment, including provisions for emergency treatment at all times
- .Dental hygiene program
- .Psychological testing and counseling when provided routinely to all clients
- .Psychiatric examination and treatment when provided routinely for facility clients
- .Medical appliance upkeep, repairs, and purchase of medical supplies for the general facility population

The cost for the above services will be limited to that which is considered reasonable not to exceed the medicaid payment where applicable.

Expenses associated with extraordinary medical services provided to individual clients may be subject to direct reimbursement as Tier 3 expenses. See section 3.7 for guidelines and procedures related to Tier 3 reimbursement.

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i. Income Producing Expenses

Any income from such items as sale of medical records, sale of scrap and waste, rental of space, etc. (when the item was included as an allowable cost) shall be offset.

j. Transportation Costs

Allowable costs include transportation intrinsic to the well-being of the client, including but not limited to visits with relatives, prospective foster or adoptive parents, and other activities or events that are an integral part of the 24-hour program of care and not available through another resource. Expenses for an attendant, when required, may be allowed if not already charged to the State's program under Titles XIX, XX, IV-B, or other publicly funded programs.

k. Other Non-Allowable Expenses

- (1) Appraisal costs
- (2) Capital expenditures
- (3) Collection costs
- (4) Remuneration for directors on the facility's Board of Directors. This does not include reimbursement for expenses.
- (5) Educational costs

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- (6) Fines, penalties, judgments or settlements of any kind
  - (7) Any costs not related to care in the facility, including depreciation
  - (8) Payments made by the facility as gifts, assessments or paybacks to parent organizations
  - (9) Expenses reimbursable by other State or Federally funded programs
  - (10) Vending machine expenses
  - (11) Expenses for gifts, flower and coffee shops
  - (12) Depreciation of equipment used to secure self-generated revenue
1. Clothing Cost

Clothing cost will be allowed up to an average annual maximum of \$400 per client based on the anticipated and approved occupancy.

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m. Start-up costs

In the period of developing a facility's ability to furnish client care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to client care services rendered after the time of preparation, they may be capitalized as deferred charges and amortized. Start-up costs include allowable costs incident to the start-up period. Costs that are properly identifiable as organization costs or capitalized as construction costs must be appropriately classified as such and excluded from start-up costs.

Start-up costs are amortized over a period of 60 months, beginning from the month of first admission of a client.

Facilities who began operation prior to July 1, 1984, whose start up costs were not amortized and included in the rate, will be allowed 1/60th amortization of these costs for the months remaining after July 1, 1984.

Example: If a facility began operations in July 1983, the amortization of costs would be 1/60th per month for 48 months.

Refer to HIM-15, 2132 for further regulations concerning start up costs.

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n. Revaluation of Assets

In establishing an appropriate allowance for depreciation, interest on capital indebtedness and, if applicable, a return on equity capital with respect to an asset of a facility which has undergone a change of ownership, the valuation of the asset will be the lesser of the allowable acquisition cost of the asset to the first owner of record on or after July 18, 1984, or the acquisition cost of such asset to the new owner. Costs of legal fees, negotiation, or settlement of the sale are not reimbursable.

F. Instructions for Explanations of Adjustments  
(Schedule C-3)

Enter Schedule, Line Number, Explanation and Amount as shown in Schedules C-1 and C-2 column (b). See Adjustments under Section 3.5 E above for further information.

G. Instructions for Cost Category Tables (Schedule C-4)

1. Enter totals from appropriate schedules and lines as outlined on forms
2. Enter client days as required.

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#### H. Instructions for Depreciation (Schedule D)

##### 1. Schedule D

Include in this schedule only assets which relate to client care and provide the information needed as shown. For the Budget Period, include anticipated purchases of depreciable items during the budget period.

##### 2. Depreciation

An appropriate allowance for depreciation on buildings and equipment related directly to client care services is an allowable cost. Depreciation must be computed by the straight-line method only. The estimated useful life of fixed assets will be based on the Internal Revenue Service's approved useful life of fixed assets. Depreciation will be allowed only on buildings and equipment related to direct client care services. Facilities must maintain adequate records to determine cost, value, and reasonable useful life of buildings and equipment.

Assets must be capitalized if cost is at least \$500 and if they have a useful life of at least two years.

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To be allowable the depreciation must:

1. Be identifiable and recorded in the provider's records.
2. Give historical cost and accumulated depreciation.
3. Indicate useful life and depreciation method.

If provider has previously used an accelerated depreciation method, the required record keeping information may be kept in a subsidiary ledger to be used for program purposes only.

The following guidelines are average ranges for asset depreciation. For all depreciable assets, even those not included in the guidelines, an estimate is acceptable if it is proven reasonable.

<u>Land Improvements</u>	<u>Years</u>
Fencing	15-25
Paving	15-20
Landscaping	10-12
Underground sewer and water	25-30
Outdoor Lighting	10-15
<u>Buildings</u>	
Wood Frame	25-30
Masonry	30-50

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Fixed Equipment

Electrical Wiring, AC Systems,  
Heating Systems, Sprinkler and  
Fire Alarm Systems, Telephone, Plumbing  
Sewerage, Roofing, Lighting, etc. 20-25

Major Movable Equipment

Kitchen Equipment, Therapy Equipment,  
Laundry Equipment, Cleaning Equipment, etc. 8-20

Other Items

Automobiles 3-05  
Furniture and Furnishings 5-10  
Office Machines 5-10

Depreciation of assets being used by a vendor at the time he enters the program is allowed; this applies even though such assets may be fully or partially depreciated on the vendor's books.

So long as an asset is being used, its useful life is considered not to have ended, and consequently the asset is subject to depreciation based on a revised estimate of the asset's useful life as determined by the Provider and approved by Rate Administration.

For example, if a fifty year old building is used at the time the vendor enters the program, depreciation is allowable on the building even though it has been fully depreciated on the vendor's books. Assuming that a

reasonable estimate of the asset's continued life is twenty years, (seventy years from the date of acquisition) the vendor may claim depreciation over the next twenty years -- if the asset is in use that long -- or a total depreciation to the program of as much as twenty-seventieths of the asset's historical cost.

1. Instructions for In-Kind Contributions  
(Schedules E-1 and E-2)

1. Complete Schedule E-1 for in-kind contributions received during the cost report period. Complete Schedule E-2 for in-kind contributions anticipated during the budget period.
2. Valuation of In-Kind Contributions

In-kind contributions represent the value of non-cost contributions related to the direct care of clients provided by private organizations and individuals. In-kind contributions may consist of charges for real property and equipment and value of goods and services directly benefiting and specifically identifiable to all clients in the approved program.

Specific procedures for the facilities in placing a value on in-kind contributions from private organizations and individuals are set forth below:

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a. Valuation of volunteer services: Volunteer services may be counted as a program cost only if the requirements of HIM 15, Paragraphs 700 through 706 are met. In order to qualify under this section volunteers must work more than 20 hours per week in various types of full-time positions that are normally occupied by paid personnel of providers not operated by or related to religious orders. Services must be related directly to client care or in administrative positions essential to the provision of that care. Volunteers must be members of an organization of non paid workers that has arrangements with the provider for the performance of services by volunteer workers without direct remuneration to the volunteer by either organization.

(1) Value for volunteer services: Value for volunteers cannot exceed the amounts for regular working hours (excluding overtime) of paid employees who perform similar services. If there are no similar positions within the organization, the valuation cannot exceed the amount paid for such services by other providers in the area of similar size, scope of services, and utilization.

Normal fringe benefits can be included in the valuation, but social security taxes, workmen's compensation, State unemployment insurance and any other costs stemming from

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b. Valuation of donated equipment, buildings, and land, or use of space: The value of donated property will be determined as follows:

- (1) Equipment and buildings: The value of donated equipment or buildings should be based on the donor's cost less depreciation or the current market prices of similar property, whichever is less. The current market price should be established by a recognized appraisal expert. The title of the donated equipment and building must be legally in the name of the facility.
- (2) Land or use of space: The value of donated land should be based on the donor's cost or the current market price of similar property. The current market prices should be established by a recognized appraisal expert. Use of space will not be considered in determining allowable cost with one exception. The exception is if the provider and the donor organization are both part of a larger organizational entity, such as units of a state or parish government, the cost related to the donated space is includable in the allowable cost of the provider.

- c. Valuation of Other Charges: Other necessary charges incurred specifically for an indirect benefit to the program on behalf of all clients may be accepted as program costs provided they are adequately supported and permissible under the approved program. Such charges must be reasonable and properly documented.

Consultants, such as pharmacy consultants, not qualifying under the provisions for valuation of volunteer services, will qualify for valuation under this section, provided the service is an integral and necessary part of an approved program.

The following requirements pertain to the facility's supporting records for in-kind contributions from private organizations and individuals:

- .The extent of volunteer services must be supported by the same methods used by the facilities for its employees.
- .The basis for determining the charges for personal services, equipment, and buildings must be documented.

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J. Instructions for Certification Statement (Schedule F)

An owner, officer or administrator and the preparer (CPA, Accountant, Bookkeeper, etc.) will complete the certification statement.

NOTE: Cost Reports will not be accepted if the certification statements are not signed, or a comparable letter from the preparer is not attached.

CPA's may include the standard disclaimers for unaudited statements.

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L. Cost Report and Budget Form  
and Supporting Schedules

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3.6 Payment and Contractual Considerations

A. Regular Per Diem Payment

Providers are paid a rate per client care day ("per diem" rate) determined in accordance with Part 3.0 of this manual. Payment is made monthly and based upon actual occupancy of the prior month.

1. FADS Procedures

See FADS Procedures Manual for details regarding payment procedures.

2. MHIS

Refer to OFS or Medicaid fiscal agent for detailed payment procedures.

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#### B. Exceptions to Regular Per Diem

An individual program office may, at its option, contract with a provider on a basis other than per diem times actual client days. Such a decision would be subject to the limitations of the payment mechanism (e.g., FADS, MNIS, etc.) used by that office. Contractual options available to the program offices include, but are not limited to, the following:

##### 1. Total Capacity Contract

In certain instances, the Department may contract with a provider for the total capacity of a facility. Payment, in such cases, is based upon total available days without regard to actual occupancy. This is not available for facilities funded under Title XIX.

##### 2. Scheduled Occupancy Contract

The Department may desire to contract with a provider on the basis of a projected monthly schedule of occupancy. In such cases payment would be based upon the occupancy as scheduled, with adjustments made for actual occupancy according to the terms of the contract and Title XIX regulations, if applicable. It is intended that total payment to the provider in such cases will, on an annual basis, approximately equal that which would have been paid on the basis of actual occupancy.

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3. Minimum Capacity Contract

In some cases it may be considered desirable to contract with a provider for a specified minimum capacity. Such contracts will provide for payment based upon actual occupancy or the contract minimum, whichever is greater. Such contracts would have to comply with Title XIX regulations, if applicable.

When contracting with the Department for payment under any of the three exceptions to the regular per diem noted above, the facility must agree, within limits, to accept and care for clients referred to them. In this regard such facilities may not exercise the same freedom of choice in accepting clients as other facilities. The specific terms of the contract will govern in determining limits to the provider's right of rejection of clients.

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### 3.7 Reimbursement of Other Expenditures - Tier 3

Facilities can be reimbursed for specific expenses over and above their daily rates only under the following circumstances:

1. The client's individual plan of care specifies needs which cannot be met within the facility's normally planned operation.
2. The expenditure meets specific criteria established by the Rate Setting Policy Committee.
3. Written authorization has been received at the required level (regional office, program office or departmental).
4. The expenditure is not covered under the Basic Support and Programmatic components of the facility's per diem rate.
5. The expenditure is not fundable under the Title XIX vendor payment program.
6. Other sources of funds have been exhausted.

The procedure for payment varies according to the payment mechanism used by the program office for the facility. Tier 3 revenue must be reflected on the appropriate line of the Income Statement (Cost Report and Budget Form, Schedule B, Line 9) for the period in which reimbursement was received. The expense should be reflected with an adjustment on the appropriate schedule.

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3.8 Auditing and Monitoring

All providers will be subject to an audit of their books and records from time to time by representatives of the Department of Health and Human Resources. The audit will be designed to gain assurances including, but not limited to, the following:

that monies allocated and paid to the provider by the Department for services to clients are properly used for the purpose intended as reflected in the cost reports submitted by the provider

that non-allowable costs are properly reflected

that costs are properly reflected on reports to the Department, and that significant misclassifications have not occurred

that reported occupancy is accurate

New providers will be subject to a desk audit after the conclusion of their first year of operation. Ongoing providers will be subject to desk audit on a random sample basis. Field audits will be conducted of a reasonable number of providers each year. Providers submitting budgets exceeding the budget screen amount for their group will be subject to a greater probability of audit than providers submitting budgets below the budget screen.

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Errors in submitted cost reports greater than 10% in the aggregate for the provider for the year of the cost report will result in penalties being assessed against the provider. A maximum penalty of 10% on the per diem in effect when the error is determined may be imposed.

Errors in documentation submitted by providers to justify projected costs, misstatements in the budget concerning related organization transactions, balance sheet errors, depreciation errors, and in-kind contribution errors, may result in a recomputation of the rate(s) affected by the errors or misstatements.

Programmatic and quality of care monitoring for all providers will be the responsibility of the individual program offices. Program offices, in conjunction with Rate Administration, will be responsible for fiscal monitoring on an ongoing basis, with special emphasis on new providers and "Special Providers".

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Programmatic and quality of care monitoring for all providers will be the responsibility of the individual program offices. Program offices, in conjunction with Rate Administration, will be responsible for fiscal monitoring on an ongoing basis, with special emphasis on new providers and "Special Providers".

State of Louisiana
Department of Health and Hospitals
Cost Report for Adult Day Health Care Providers

Cost Report Period: From: \_\_\_\_\_ To: \_\_\_\_\_

Date Cost Report Completed: \_\_\_\_\_

Corporate Name: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Contact Email Address: \_\_\_\_\_

Telephone Number (Voice): \_\_\_\_\_

Telephone Number (Fax): \_\_\_\_\_

Vendor Number: \_\_\_\_\_

Type of Control

Select Only One

Nonprofit

- 1 \_\_\_\_\_ Church Related
2 \_\_\_\_\_ Private
3 \_\_\_\_\_ Other
(Specify)

Proprietary

- 1 \_\_\_\_\_ Individual
2 \_\_\_\_\_ Partnership
3 \_\_\_\_\_ Corporation

Governmental

- 1 \_\_\_\_\_ State
2 \_\_\_\_\_ Parish
3 \_\_\_\_\_ City
4 \_\_\_\_\_ City-Parish
5 \_\_\_\_\_ Other
(Specify)

**Statistical Data**

**Facility Name:** \_\_\_\_\_

1. Licensed Capacity at Beginning of Cost Report Period: \_\_\_\_\_

2. Licensed Capacity at End of Cost Report Period: \_\_\_\_\_

3. Effective Date of Change in Licensed Beds (if any) \_\_\_\_\_

4. Total Client Days Available

5. Client Days Paid and Payable at end of Period:

A. Medicaid Days \_\_\_\_\_

B. Other State Client Days \_\_\_\_\_

C. Private Client Days \_\_\_\_\_

Total Client Days ( A + B + C )

6. Occupancy Percentage  
(Line 5 divided by Line 4) \_\_\_\_\_



**Ownership (cont'd)**

**Facility Name:** \_\_\_\_\_

4. In the amount of costs reported, are any costs included which are a result of transactions with related parties or organizations as defined in the Medicare Provider Reimbursement Manual (HIM-15)?

\_\_\_\_\_ **YES (if "yes", complete parts a. & b.)** \_\_\_\_\_ **NO**

a. List costs incurred as a result of transactions with related parties/organizations

<u>Schedule No.</u>	<u>Line Item No.</u>	<u>Line Item Title</u>	<u>Amount Reported</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

b. List names of related parties, organizations & relationships

<u>Name of Related Party</u>	<u>Name of Related Organization</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Staff and Other Information**

Facility Name: \_\_\_\_\_

1. Total number of employees for the last payroll: \_\_\_\_\_

2. Number of Minimum Wage Employees: \_\_\_\_\_

3. Position Summary Full Time  
Equivalents

a. Direct Care \_\_\_\_\_

b. Care Related \_\_\_\_\_

c. Administrative and Operating \_\_\_\_\_

Total Full Time Equivalents (a + b + c) \_\_\_\_\_

4. Fringe Benefits Provided (check if provided)

a. \_\_\_\_\_ Life Insurance

b. \_\_\_\_\_ Health Insurance

c. \_\_\_\_\_ Retirement Plan

d. \_\_\_\_\_ Uniforms

e. \_\_\_\_\_ Meals

f. \_\_\_\_\_ Other (Describe) \_\_\_\_\_

g. \_\_\_\_\_ Other (Describe) \_\_\_\_\_

h. \_\_\_\_\_ Other (Describe) \_\_\_\_\_

**Staff and Other Information (Cont'd)**

Facility Name: \_\_\_\_\_

5. Number of vehicles owned or leased by facility \_\_\_\_\_

6. Number of mortgages on fixed assets \_\_\_\_\_

	Original Date	Amount	Interest Rate	Amortization Period
a. First Mortgage	_____	_____	_____	_____
b. Second Mortgage	_____	_____	_____	_____
c. Third Mortgage	_____	_____	_____	_____

7. Other rates received

a. Private client rate \_\_\_\_\_

b. Other state or federal rates \_\_\_\_\_

c. Other (Specify) \_\_\_\_\_



**Balance Sheet - Assets**

Facility Name: \_\_\_\_\_

Period Ending: \_\_\_\_\_

ACCOUNTS	<u>Balance Sheet Per Books</u>
Current Assets:	
1 Cash on Hand	_____
2 Accounts Receivable	_____
3 Notes Receivable	_____
4 Other Receivables	_____
5 Less: Allowance for uncollectibles Accounts Rec. & Notes Rec.	_____
6 Inventory	_____
7 Prepaid Expenses	_____
8 Investments	_____
9 Other (Specify) _____	_____
10 TOTAL CURRENT ASSETS	<u>0</u>
Fixed Assets:	
11 Land	_____
12 Buildings	_____
13 Less: Accumulated Depreciation	_____
14 Leasehold Improvements	_____
15 Less: Accumulated Depreciation	_____
16 Fixed Equipment	_____
17 Less: Accumulated Depreciation	_____
18 Major Movable Equipment	_____
19 Less: Accumulated Depreciation	_____
20 Motor Vehicles	_____
21 Less: Accumulated Depreciation	_____
22 Minor Equipment (non-depreciable)	_____
23 TOTAL FIXED ASSETS	<u>0</u>
Other Assets:	
24 Investments	_____
25 Deposits on Leases or Utilities	_____
26 Due from Owners/Officers	_____
27 Due to funds	_____
28 Other (Specify) _____	_____
29 TOTAL OTHER ASSETS	<u>0</u>
30 TOTAL ASSETS (sum of lines 10, 23 & 29)	<u><u>0</u></u>

**Balance Sheet - Liabilities**

Facility Name: \_\_\_\_\_

Period Ending: \_\_\_\_\_

ACCOUNTS

Balance Sheet  
Per Books

Current Liabilities:

31	Accounts Payable	_____	
32	Notes Payable	_____	
33	Current Portion of LT Debt	_____	
34	Salaries - Fees Payable	_____	
35	Payroll Taxes Payable	_____	
36	Deferred Income	_____	
37	Other (Specify) _____	_____	
38	TOTAL CURRENT LIABILITIES	_____	<b>0</b>

Long-Term Liabilities:

39	Mortgages Payable	_____	
40	Notes Payable	_____	
41	Unsecured Loans	_____	
42	Loans from Owners	_____	
43	TOTAL LONG-TERM LIABILITIES	_____	<b>0</b>

44 TOTAL LIABILITIES (sum of lines 38 and 43) \_\_\_\_\_ **0**

45 Capital:

45a	Other (Specify) _____	_____	
45b	Other (Specify) _____	_____	
45c	Other (Specify) _____	_____	

46 TOTAL CAPITAL \_\_\_\_\_ **0**

47 TOTAL LIABILITIES AND CAPITAL (sum of lines 44 & 46) \_\_\_\_\_ **0**

**Income Statement**

Facility Name: \_\_\_\_\_  
Cost Report Period: \_\_\_\_\_

Routine Service Income:

1	Medicare	_____
2	SSI / SSA	_____
3	Medicaid	_____
4	Other State Revenue	_____
5	Private	_____
6	Grants*	_____
	a. Federal	_____
	b. State	_____
7	<b>Other (Specify)</b> _____	_____
8	Total Routine Service Income	<b>0</b>

Other Income:

9	Special expense reimbursement	_____
10	Donations	_____
	a. Restricted	_____
	b. Unrestricted	_____
11	Sale of Drugs	_____
12	Therapy	_____
13	Sale of Supplies	_____
14	Employee and Guest Meals	_____
15	Interest	_____
16	Rentals	_____
17	Beauty or Barber Shop	_____
18	Vending Machine	_____
19	Miscellaneous <b>Specify</b> _____	_____
20	Total Other Income:	<b>0</b>
21	Total Income (Line 8 + Line 20)	<b>0</b>

Less Refunds and Allowances\*\*

22	Medicare	_____
23	SSI / SSA	_____
24	Medicaid	_____
25	Other State Revenue	_____
26	Private	_____
27	Other	_____
28	Total Refunds and Allowances	<b>0</b>
29	Net Income (Line 21 minus 28)	<b>0</b>

\* State type of grant, period covered; if more than one, list separately.  
If grant is continuous or declining, state percentages or amounts.

\*\* Indicate amount reimbursed or credited to DHH (if any).

Schedule A

Facility Name: \_\_\_\_\_

Cost Report Period: \_\_\_\_\_

Expense Classification		Expenses per Books (a)	Adjustments (b)	Allowable Expenses (c)
<b>A. Direct Care Costs</b>				
1	Salaries - Aides			
2	Salaries - LPNs			
3	Salaries - RNs			
4	Salaries - Social Services			
5	Salaries - Activities (excl. Act. Dir.)			
6	<b>Payroll Taxes</b>			
	a. F. I. C. A.			
	b. F. U. T. A.			
	c. S. U. T. A.			
	d. Medicare Tax			
7	<b>Employee Benefits</b>			
	a. Group Insurance			
	b. Pensions			
	c. Uniforms & Allowances			
	d. Other (Specify) _____			
8	Workers' Compensation			
9	Contract - Aides			
10	Contract - LPN's			
11	Contract - RN's			
12	Contract - Social Services (MSW)			
13	Drugs - OTC & Non-Legend			
14	Medical Supplies			
15	Medical Waste Disposal			
16	Other Supplies			
17	Allocated Costs-Hospital Based			
18	Miscellaneous _____			
	(Specify) _____			
<b>Total Direct Care Costs</b>		<b>0</b>	<b>0</b>	<b>0</b>

**Schedule B**

Facility Name: \_\_\_\_\_

Cost Report Period: \_\_\_\_\_

Expense Classification		Expense per Books (a)	Adjustments (b)	Allowable Expenses (c)
<b>B</b>	<b>Care Related Costs</b>			
1	Salaries-Supervisory Staff			
2	Salaries-Dietary			
3	<b>Payroll Taxes</b>			
	a. F.I.C.A.			
	b. F.U.T.A.			
	c. S.U.T.A.			
	d. Medicare Tax			
4	<b>Employee Benefits</b>			
	a. Group Insurance			
	b. Pensions			
	c. Uniforms/Allowance			
	d. Other (Specify)			
5	Workmens' Compensation			
6	Consultant Fees			
	a. Activities			
	b. Nursing			
	c. Pharmacy			
	d. Social Worker			
	e. Therapists			
7	Food-Raw			
8	Food-Supplements			
9	Supplies			
10	Allocated Costs - Hospital Based			
11	Miscellaneous (Specify)			
	<b>Total Care Related Costs</b>	<b>0</b>	<b>0</b>	<b>0</b>

**Schedule C**

Facility Name: \_\_\_\_\_

Cost Report Period: \_\_\_\_\_

Expense Classification	Expense per Books (a)	Adjustments (b)	Allowable Expenses (c)
<b>C Administrative and Operating Costs</b>			
1 Salaries - Administrator			
2 Salaries - Asst. Administrator			
3 Salaries - Housekeeping			
4 Salaries - Laundry			
5 Salaries - Maintenance			
6 Salaries - Drivers			
7 Salaries - Other Administrative			
8 Salaries - Owner or Owner/Admin.			
<b>9 Payroll Taxes</b>			
a. F.I.C.A.			
b. F.U.T.A.			
c. S.U.T.A.			
d. Medicare Tax			
<b>10 Employee Benefits</b>			
a. Group Insurance			
b. Pensions			
c. Uniforms / Allowance			
d. Other (Specify) _____			
11 Workers' Compensation			
12 Contract - Dietary			
13 Contract - Housekeeping			
14 Contract - Laundry			
15 Contract - Maintenance			
16 Consultant Fees - Dietician			
<b>ADMINISTRATIVE &amp; OPERATING SUBTOTAL</b>	<b>0</b>	<b>0</b>	<b>0</b>

**Schedule C (cont'd)**

Facility Name: \_\_\_\_\_

Cost Report Period: \_\_\_\_\_

Expense Classification		Expense per Books (a)	Adjustments (b)	Allowable Expenses (c)
17	Accounting Fees			
18	Amortization Expense Non-Capital			
19	Bank Service Charge			
20	Board of Directors' Fees			XXXXXXXX
21	Dietary Supplies			
22	Dues			
23	Educational Seminars and Training			
24	Housekeeping Supplies			
25	Insurance - Professional Liability and Other			
26	Interest on Non-Capital and Vehicles			
27	Laundry Supplies			
28	Legal Fees			
29	Linen Supplies			
30	Management Fees and Home Office Costs			
31	Non-emergency Medical Transportation			
32	Office Supplies and Subscriptions			
33	Postage			
34	Repairs & Maintenance			
35	Taxes and License			
36	Telephone & Communications			
37	Travel			
38	Vehicle Expenses (Gas, oil, etc.)			
39	Utilities			
40	Allocated Costs - Hospital Based			
41	Maintenance Supplies			
42	Miscellaneous (Specify)			
<b>TOTAL ADMINISTRATIVE AND OPERATING COSTS</b>		<b>0</b>	<b>0</b>	<b>0</b>

**Schedule D**

Facility Name: \_\_\_\_\_

Cost Report Period: \_\_\_\_\_

Expense Classification		Expense per Books (a)	Adjustments (b)	Allowable Expenses (c)
<b>D Property and Equipment</b>				
1	Amortization Expense - Capital			
2	Depreciation Expense - (Provide detailed schedules)			
	a. Depreciation - Buildings			
	b. Depreciation - Furn. & Equip.			
	c. Depreciation - Motor Vehicles			
	d. Depreciation - Leasehold Imp.			
3	Interest Expense - Capital			
4	Property Insurance			
5	Property Taxes			
6	Rent - Building			
7	Rent - Furniture & Equipment			
8	Auto Lease			
9	Allocated Costs - Hospital			
10	Miscellaneous (Specify)			
<b>TOTAL PROPERTY &amp; EQUIPMENT</b>		<b>0</b>	<b>0</b>	<b>0</b>

Schedule E

Calculation of Costs Per Day by Category

Facility Name: \_\_\_\_\_

CR Period: \_\_\_\_\_

Expense Classification	Allowable Expenses (a)	Divided By Total Client Days (b)	Costs Per Day (c)
A Direct Care Costs	0	0	\$0.00
B Care Related Costs	0	0	\$0.00
C Admin & Operating	0	0	\$0.00
D Property & Equipment	0	0	\$0.00
Total Cost Per Day	0	0	\$0.00

Schedule F

Facility Name: \_\_\_\_\_

CR Period: \_\_\_\_\_

Direct Care Cost Settlement

	(a)		(b)	=	(c)		(d)
	<u>Medicaid Days</u>		<u>Direct Care Rate Component</u>		<u>Medicaid Direct Care Revenue</u>		<u>Medicaid Direct Care Revenue 90%</u>
1	<u>0</u>	X	_____	=	<u>\$0.00</u>		<u>\$0.00</u>

	(a)		(b)		(c)
	<u>Medicaid Days</u>		<u>Direct Care Costs Per Day</u>		<u>Medicaid Direct Care Allowable Costs</u>
2	<u>0</u>	X	<u>\$0.00</u>		<u>\$0.00</u>

3 **Due to State** Subtract Line 2 (c) from Line 1 (d).  
 (If less than zero, then enter zero.) **\$0.00**





**SCHEDULE D - DEPRECIATION SCHEDULE**

Facility Name:

From:

To:

Description (a)	Date Acquired (b)	Expected Life (c)	Cost (d)	Reserve for Depreciation Begin Period (e)	Depreciation Expense (f)	Retirements (g)	Reserve for Depreciation End of Period (h)	Book Value (i)
<b>TOTALS</b>								

NOTE: If additional space is required, please attach schedule. An asset must be capitalized if the cost is at least \$5,000 and the asset has a useful life of at least two years.

**Schedule G  
Certification Statement  
by  
Preparer and Owner, Officer, or Administrator**

I, \_\_\_\_\_ , \_\_\_\_\_  
**Name Administrative Title**

of, \_\_\_\_\_ , do certify that I have  
**Name of Facility**

examined the attached report for the cost report period beginning \_\_\_\_\_ and  
ending \_\_\_\_\_ , and to the best of my knowledge and belief, it is a true and  
correct statement of the information required.

**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**CERTIFICATION BY ACCOUNTANT**

I have prepared the Adult Day Health Care Cost Report of

\_\_\_\_\_ for the cost report  
**Name of Facility**

period beginning \_\_\_\_\_ and ending \_\_\_\_\_ ,

and in my opinion, except for the comments stated below, all information contained in the Adult  
Day Health Care Cost Report is fairly stated and in accordance with the instructions furnished by  
Louisiana Department of Health and Hospitals Administration and the Principles of Reasonable  
Cost as set forth in the Provider Reimbursement Manual (HIM-15).

**Date:** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **Instructions for Completing Adult Day Health Care Cost Report**

### **Page 1**

#### **Identifying Information**

Report in the spaces provided the corporate and facility name, address, mailing address if different from street address, Title XIX vendor number and accounting period. The name and telephone number of a contact person should be specified.

#### **Type of Control**

Check one appropriate block.

### **Page 2**

#### **Statistical and Other Data**

1. Enter licensed capacity at beginning of the period.
2. Enter licensed capacity at end of the period.
3. Enter effective date of change in licensed capacity, if applicable.
4. Enter client days available (licensed capacity times days the facility was open for the period).
5. Enter the client days in the appropriate category.  
Enter total (sum of a, b and c).
6. Enter percent of occupancy (line 5 divided by line 4)

### **Page 3**

#### **Ownership and Related Organization**

1. List all owners or board of directors and relatives of owners or board of directors employed by the facility.
2. If changes in ownership, licensure, or certification occurred during the report period, enter the changed information (from -- to) and date of each change.

3. If facility or equipment is leased or rented, give name of owner of each leased asset, relationship to the facility, and terms of the lease. A copy of lease or rental agreements in effect during the report period must be attached to the cost report.

#### **Page 4**

4. If the facility has related party transactions as defined in the HIM-15, complete a. and b.

#### **Page 5**

##### Staff and Other Information

1. Indicate total number of employees for the last payroll in the period.
2. Indicate number of minimum wage employees
3. For each category, indicate the full time equivalent (total hours divided by 40). Indicate total full time equivalent.
4. Benefits provided employees -- check each type of benefits provided for one or more employees. Describe any other benefits provided.

#### **Page 6**

##### Staff and Other Information Cont'd

5. Number of vehicles owned or leased by facility - Enter the number of cars, trucks, vans, and station wagons owned or leased by the facility. Do not include boats, airplanes, etc.
6. Number of mortgages on fixed assets - enter number. Indicate original date, amount, and interest rate on each - enter date, amount, and interest rate for first, second, and third mortgage.
7. Indicate other non-Medicaid rates received.

#### **Page 7**

##### Staffing Pattern

Complete staffing pattern for each position and indicate line item number.

## **Page 8**

### **Balance Sheet-Assets**

Enter appropriate balance sheet asset accounts per books as of the end of the cost report period.

## **Page 9**

### **Balance Sheet-Liabilities**

Enter appropriate balance sheet liability and equity accounts per books as of the end of the cost report period.

## **Page 10**

### **Income Statement**

Enter appropriate income account balances per books as of the end of the period.

## **Page 11**

### **Direct Care Costs**

Column (a) - Enter expenses for the cost report period from the General Ledger. Amounts entered in this column must agree with the expenses in the General Ledger.

Column (b) - Enter adjustments to expenses per books for the cost report period. Offsets for grants, restricted donations, vending machine income, unallowable costs, etc. should be included in this column.

Column (c) -- Enter net allowable expenses for the cost report period: Column (a) plus or minus adjustments in Column (b).

Carry total of Column (c) to page 16, Line A, column (a).

## **Page 12**

### **Care Related Costs**

Column (a) - Enter expenses for the cost report period from the General Ledger. Amounts entered in this column must agree with the expenses in the General Ledger.

Column (b) - Enter adjustments to expenses per books for the cost report period. Offsets for grants, restricted donations, vending machine income, unallowable costs, etc. should be included in this column.

Column (c) -- Enter net allowable expenses for the cost report period: Column (a) plus or minus adjustments in Column (b).

Carry total of Column (c) to page 16, Line B, column (a).

### **Pages 13 and 14**

#### **Administrative and Operating Costs**

Column (a) - Enter expenses for the cost report period from the General Ledger. Amounts entered in this column must agree with the expenses in the General Ledger.

Column (b) - Enter adjustments to expenses per books for the cost report period. Offsets for grants, restricted donations, vending machine income, unallowable costs, etc. should be included in this column.

Column (c) -- Enter net allowable expenses for the cost report period: Column (a) plus or minus adjustments in Column (b).

Carry total Column (c) to page 16, Line C, column (a).

### **Page 15**

#### **Property and Equipment**

Column (a) - Enter expenses for the cost report period from the General Ledger. Amounts entered in this column must agree with the expenses in the General Ledger.

Column (b) - Enter adjustments to expenses per books for the cost report period. Offsets for grants, restricted donations, vending machine income, unallowable costs, etc. should be included in this column.

Column (c) -- Enter net allowable expenses for the cost report period: Column (a) plus or minus adjustments in Column (b).

Carry total of Column (c) to page 16, Line D, column (a).

A copy of the depreciation schedule must be attached for each line item reporting depreciation expense.

## **Page 16**

### Calculation of Costs Per Day by Category

Divide Column (a) (Allowable Expenses) by Column (b) (Total client days reported on page 2.) to calculate Column (c) Cost Per Day for each category. Enter the sum of Lines A., B., C., and D. in column (c) for Total Cost per Day.

## **Page 17**

### Direct Care Cost Settlement

1. Multiply the Direct Care Rate Component (Column (b)) by the number of Medicaid days Column (a) (days reported on page 2, 5., a.) to calculate Direct Care Revenue Column (c). Multiply Medicaid Direct Care Revenue Column (c) by 90%, enter amount in Column (d). This amount is used for the cost settlement calculation.

2. Multiply Medicaid days Column (a) (days reported on page 2, 5., a.) times the Direct Care cost per day from Line A, Column (c), page 16 to calculate Medicaid Direct Care Allowable Costs, enter in Column (c). Subtract line 2., (c) from line 1., (d) to calculate the amount Due to State.

3. Enter amount Due to State. (If amount is less than "0", enter "0".)

A check payable to Department of Health and Hospitals must be submitted with the cost report when the calculation indicates money due to the State.

## **Pages 18 and 19**

### Schedule of Adjustments

Enter the information for each adjustment on these pages.

## **Page 20**

### Certification Statement

This page must be completed, signed and dated by the Representative of the facility and the person preparing the cost report.



Kathleen Babineaux Blanco  
GOVERNOR

STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS



Frederick P. Cerise, M.D., M.P.H.  
SECRETARY

August 17, 2007

MEMORANDUM

TO: ADMINISTRATORS OF ADHC FACILITIES

FROM: KENT BORDELON, DIRECTOR  
RATE AND AUDIT REVIEW

RE: SUBMISSION OF 2006-2007 COST REPORTS

This letter is to inform you that annual cost reports (facility, central office) must be submitted by October 1, 2007. These reports cover the period July 1, 2006 through June 30, 2007.

Enclosed is a revised page 17 of the cost report. Due to the wage increase effective 2/9/07 there are two Direct Care Component amounts within the fiscal year. The component amount for 7/1/07 through 1/31/07 is \$27.49 and for 2/1/07 through 6/30/07 is \$28.60 (as indicated on the enclosed rate letters). This revised page will be used for 06-07 fiscal year only and must be submitted with your cost report.

Please note that cost report software is available free of charge on the internet at <http://www.medimax.com>. Providers that do not have access to the internet may obtain the software free of charge by contacting Gary Carlisle at 318/263-9474. Mr. Carlisle is available to answer your questions or assist you if software problems are encountered. We recommend that providers use this software for all cost reports (LA ADHC Provider xls).

It is necessary that you submit the original and one (1) copy of each cost report. In addition, submit one (1) diskette for each cost report when Medimax cost report software is used. Faxed cost reports will not be accepted.

If a provider experiences unavoidable difficulties in preparing its cost report by the prescribed due date. A 30 day extension may be requested. Written requests must be received prior to the due date by Rate and Audit Review at the post office box

**Administrator of ADHC Facilities**  
**August 17, 2007**  
**Page 2**

**listed below, attention Beth Taranto. There shall be no automatic extension of time for the filing of cost reports. The request shall explain in detail why the extension is necessary.**

**If cost reports and all accompanying forms are not postmarked by October 1, 2007 (or October 31, 2007 if an extension is granted) penalties may be assessed as outlined in Section 3.5, A.2. of the DHH Rate Setting Manual.**

**If the calculation of Direct Care Cost Settlement shows money due to the Department don't remit payment with the cost report. Provider will be notified of amount due after desk review or audit.**

**Attached are the maximum salary limits for the Administrator and Assistant Administrator for the fiscal years 2007 and 2008. Providers will be notified of any changes.**

**If you have any questions, please call Beth Taranto at 225/342-5773. Thank you for your cooperation.**

**KB/bt**

**cc: Missy Peroyea (P&N)**

**Schedule F**

Facility Name: \_\_\_\_\_

CR Period: 7/1/06 - 6/30/07

**Direct Care Cost Settlement**

	(a)		(b)		(c)		(d)
	<u>Medicaid Days</u>		<u>Direct Care Rate Component</u>		<u>Medicaid Direct Care Revenue</u>		<u>Medicaid Direct Care Revenue 90%</u>
<b>7/1/06 thru 1/31/07:</b>							
1a.	<u>0</u>	X	<u>\$27.49</u>	=	<u>\$0.00</u>		<u>\$0.00</u>

<b>2/1/07 thru 6/30/07:</b>							
2a.	<u>0</u>	X	<u>\$28.60</u>	=	<u>\$0.00</u>		<u>\$0.00</u>

	(a)		(b)		(c)
	<u>Medicaid Days</u>		<u>Direct Care Costs Per Day</u>		<u>Medicaid Direct Care Allowable Costs</u>
2	<u>0</u>	X	<u>\$0.00</u>		<u>\$0.00</u>

3	<b>Due to State</b>	Subtract Line 2 (c) from Line 1 (d). <b>(If less than zero, then enter zero.)</b>	<b>\$0.00</b>
---	---------------------	--	---------------

DHH Rate & Audit Review

ADHC FY07 Prospective Payment System Rate Calculation

Calculation of the PPS Rate:

Direct Care	\$27.49
Care Related	\$4.82
Administrative & Operating	\$27.66
Property	\$4.37
Total PPS rate	\$64.34

Calculation of the Direct Care Floor:

Direct Care Rate Component	\$27.49
90%	90%
Direct Care Floor	\$24.74

*DHH Rate & Audit Review*

**ADHC FY07 Prospective Payment System Rate Calculation  
Effective February 9, 2007**

Calculation of the PPS Rate:

Direct Care Base Component	\$27.49	
<b>Direct Care Wage Enhancement</b>	<b>\$1.11</b>	
Total Direct Care Component Effective February 9, 2007		\$28.60
Care Related		\$4.82
Administrative & Operating		\$27.66
Property		\$4.37
<b>Total PPS rate including Rate Enhancement Effective 2/9/2007</b>		<b>\$65.45</b>

Calculation of the Direct Care Floor:

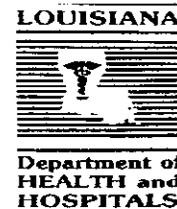
Direct Care Rate Component	\$28.60
90%	90%
Direct Care Floor Effective February 9, 2007	<b>\$25.74</b>





Kathleen Babineaux Blanco  
GOVERNOR

STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS



Frederick P. Cerise, M.D., M.P.H.  
SECRETARY

May 28, 2004

MEMORANDUM

TO: ADMINISTRATORS OF ADHC FACILITIES

FROM: KENT BORDELON, DEPUTY ASSISTANT SECRETARY  
RATE AND AUDIT REVIEW *Kent Bordelon*

RE: SUBMISSION OF 2003-2004 COST REPORTS

This letter is to inform you that annual cost reports (facility, central office) must be submitted by September 30, 2004. These reports cover the period July 1, 2003 through June 30, 2004.

Please note that cost report software is available free of charge on the internet at <http://www.medimax.com>. Providers that do not have access to the internet may obtain the software free of charge by contacting Gary Carlisle at 318/263-9474. Mr. Carlisle is available to answer your questions or assist you if software problems are encountered. We recommend that providers use this software for all cost reports (LA ADHC Provider xls).

It is necessary that you submit the original and one (1) copy of each cost report. In addition, submit one (1) diskette for each cost report when Medimax cost report software is used. Faxed cost reports will not be accepted.

If a provider experiences unavoidable difficulties in preparing its cost report by the prescribed due date, one 30 day extension may be permitted, upon written request submitted prior to the due date to Rate and Audit Review at the post office box listed below, attention Beth Taranto. There shall be no automatic extension of time for the filing of cost reports. The request shall explain in detail why the extension is necessary.

If cost reports and all accompanying forms are not postmarked by September 30, 2004, or

**Administrator of ADHC Facilities**

**May 28, 2004**

**Page 2**

**October 31, 2004 if an extension is granted, penalties may be assessed as outlined in Section 3.5, A.2. of the DHH Rate Setting Manual.**

**Attached are the maximum salary limits for the Administrator and Assistant Administrator for the fiscal years 2004 and 2005. Providers will be notified of any changes.**

**Also, attached is a revision of the capitalization rule for assets purchased by ADHC facilities. This revision is effective July 1, 2004.**

**If you have any questions, please call Beth Taranto at 225/342-5773. Thank you for your cooperation.**

**KB/JCM/bt**

LA. CIVIL SERVICE SALARY MAXIMUMS

SALARY TITLE	FISCAL YEAR 03/04 MAXIMUM	FISCAL YEAR 04/05 MAXIMUM
MR/DD REG ADM I (1-100 BEDS)	\$79,222	\$79,222
MR/DD REG ADM II (101-300 BEDS)	\$84,422	\$84,422
MR/DD REG ADM III (301-1000 BEDS)	\$89,997	\$89,997
MR/DD REG ADM IV (OVER 1000 BEDS)	\$102,352	\$102,352
MR/DD REG ASSOC ADM I (1-100 BEDS)	\$64,357	\$64,357
MR/DD REG ASSOC ADM II (101-300 BEDS)	\$73,155	\$73,155
MR/DD REG ASSOC ADM III (301-1000 BEDS)	\$78,022	\$78,022
MR/DD REG ASSOC ADM IV (OVER 1000 BEDS)	\$83,222	\$83,222

**REVISED CAPITALIZATION RULE  
FOR ADHC FACILITIES**

**The Department has revised the ADHC capitalization threshold from \$500 to \$5,000. Therefore, all assets purchased on or after July 1, 2004 at a cost below \$5,000 can be expensed and are not required to be depreciated for cost reporting purposes.**

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