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State of Louisiana
Department of Health
ADHC Cost Report

INSTRUCTIONS FOR FILING:

I **Within 90 days of cost report period end,** please send the following documentation to Myers and Stauffer through the online LA Cost Report Portal.

https://lacr.mslc.com

Required Items (Must be submitted with your filing)
Note: Use numbering below to number your attachment files as indicated (e.g., the Central Office working trial balance would be numbered "8")

ADHC Documentation
1. Signed and dated Certification Page of the Louisiana Medicaid ADHC Cost Report
2. Electronic copy of completed Louisiana Medicaid ADHC cost report in Excel.
   NOTE: The electronic copy of the Medicaid cost report MUST be submitted as **.xls or .xlsm.**
3. Grouping Schedule/Crosswalk that agrees to Schedules F, G, and H by cost report line item (must be sorted and grouped and subtotaled by cost report line item and include general ledger accounts by account number).
4. Detailed asset listing including full depreciation schedule as of the cost report period end.
5. Copy of all lease and loan agreements and any amortization schedules (*if applicable*)
6. Supporting Documentation for Schedule I adjustments.

Central Office Documentation
6. Signed and dated Certification Page of the Louisiana Medicaid ADHC Central Office Cost Report.
7. Electronic copy of completed Louisiana Medicaid ADHC cost report in Excel.
8. Grouping Schedule/Crosswalk that agrees to Schedules F, G, and H by cost report line item (must be sorted and grouped and subtotaled by cost report line item and include general ledger accounts by account number).
9. Detailed asset listing including full depreciation schedule as of the cost report period end.
10. Copy of all lease and loan agreements and any amortization schedules (*if applicable*)

II Electronic Files Should be Named in the following example formats (all files should be in .pdf except for the cost report which must be an Excel file):

Medicaid Cost Report File (provider # + Central Office Name + Facility Name + Year End in "yyyymmdd" format + "Cost Report"):
99999 CO group name - Facility name - 20090630 Cost Report.xls

If You Have One Attachment File (provider # + Central Office Name + Facility Name + Year End in "yyyymmdd" format + "CR Attachments"):
99999 CO group name - Facility name - 20090630 CR Attachments.pdf

If You Have Multiple Attachment Files (provider # + Central Office Name + Facility Name + Year End in "yyyymmdd" format + Description + Number Sequence from above list):
99999 CO group name - Facility name - 20090630 Depr Sched - 4.pdf
99999 CO group name - Facility name - 20090630 WTB - 3.pdf
etc…

All documentation should be submitted to Myers and Stauffer electronically through the online Cost Report Portal.

https://lacr.mslc.com

If you are unable to submit any documentation using the portal, email Myers and Stauffer at:

LACostReports@mslc.com

For emails sent to the LACostReports email address you MUST INCLUDE THE FOLLOWING in the subject line:
1. Identify your provider type (i.e. ADHC)
2. State your provider's name and Medicaid number

III Make a back-up copy of your electronic cost report and retain for future reference.

Please Call Myers and Stauffer at 1-800-374-6858 if you have any questions on using the template or filing the cost report.

LOUISIANA DEPARTMENT OF HEALTH

COST REPORT FOR ADULT DAY HEALTH CARE PROVIDERS

Schedule A - Facility Information

COST REPORT PERIOD: FROM: July 1, 2023 TO: June 30, 2024

DATE COMPLETED: 09/01/2024

CORPORATE NAME: Central Office, Inc.

FACILITY NAME: XYZ ADHC, Inc.

MAILING ADDRESS:

MAILING ADDRESS: 100 Main Street

MAILING CITY: Baton Rouge STATE: Louisiana ZIP: 70801 - 0012

FACILITY ADDRESS:

STREET ADDRESS: 100 Main Street

CITY: Baton Rouge STATE: Louisiana ZIP: 70801 - 0012

CONTACT PERSON: Sue Smith PHONE: (225) 555-5555 EXT:

FAX: (225) 555-4444 EXT:

E-MAIL: sue.smith@XYZ.org

TYPE OF FACILITY

ADHC Vendor Number 12345

TYPE OF CONTROL (Select only one)

Private

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE B - STATISTICAL DATA

1.	Licensed Capacity at Beginning of Cost Report Period	40	
2.	Licensed Capacity at End of Cost Report Period	40	
3.	Effective Date of Change in Licensed Capacity, if any		
4.	Total Client Days Available	10,000	This is computed by multiplying the days the center is open times the licensed capacity (usually between 240 and 260 days)
5.	Client Days at end of period *(a. + b. + c.)*		
	a. Medicaid Client Days	2,913	Lines 5a thru 5c should include all days regardless of payment source or non-payment
	b. Other State Client Days	0	
	c. Private Client Days	5	
6.	Total Client Days *(a. + b. + c.)*	2,918	
7.	Occupancy Percent *(Line 6 divided by Line 4)*	29.18%	
8.	Client Quarter Hours Paid and Payable at end of period *(a. + b. + c. + e.)*		
	a. Medicaid Client Quarter Hour Increments	95,066	Lines 8a thru 8c should include all quarter hours regardless of payment source or non-payment
	b. Other State Client Quarter Hour Increments	0	
	c. Private Client Quarter Hour Increments	121	
	d. Health Monitoring Billing Units at end of period **(Per Diem units)**	922	Health Monitoring billing units that relate to the cost report period
	e. Calculated Health Monitoring Quarter Hour Increments *(d. x 32 quarter hour increments per day)*	29,504	
9.	Total Client Quarter Hour Increments *(a. + b. + c. + e.)*	124,691	
10.	Home Delivered Meals at end of period	114	Home Delivered Meals that relate to the cost report period

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE C - OWNER AND RELATED ORGANIZATION

*All columns for owners/key officers/board members must be completed. Put zero if applicable
*All board members/key personnel should be listed for non-profit providers
*Attachments are acceptable - Should address all 5 columns

(COST REPORT IS NOT COMPLETE WITHOUT THIS INFORMATION)

1. List all owners with 5% interest or more (even if they receive no compensation) or Board of Directors and relatives of owners or Board of Directors employed by the provider.

Name	Function	% of Work Week Devoted to Business	% of Ownership	Compensation Included in Allowable Cost for This Period
Sue Smith	Administrator	100.00%	50.00%	105,206
John Smith	Owner	20.00%	50.00%	21,041
Sue Smith	Board Chair/Administraor	100.00%	0.00%	105,206
John Smith	Board Secretary	20.00%	0.00%	21,041
Thomas Jones	Board member	0.00%	0.00%	0

For profit disclosure example

Not for profit disclosure example

2. Changes in Ownership, Licensure, or Certification During Cost Report Period

Type of Change	From	To	Date of Change
n/a	n/a	n/a	

3. If the facility or any equipment is leased, give name(s) of owners(s) of leased asset(s), owner's relationship to the facility and terms of the lease. (Attach a copy of the executed lease agreements(s) effective during the cost report period).

Owner of Leased Assets	Relationship to Facility	Payments / Term
Acme Land Company	none	1000/mo
Scott Smith	owner's brother	1000/mo

If building is owned by an unrelated party

If building is owned by owner, relative of owner or board member

4. In the amount of cost 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.

a. List costs incurred as a result of transactions with related parties or organizations.

Schedule H - Part	Line Item No. & Line Item Title	Amount Reported
D	2a. Depreciation - Buildings	500
D	5 Property Taxes	2,100
D	4 Property Insurance	1,250
D	6 Rent - Building	12,000

RP rent: Correct disclosure

RP rent: Incorrect disclosure

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE C - OWNER AND RELATED ORGANIZATION

(COST REPORT IS NOT COMPLETE WITHOUT THIS INFORMATION)

C	14	Consultant Fees - Dietician	570

b. List name(s) of related parties or organizations and relationship to facility.

Name of Related Party	Name of Related Organizations	Relationship	
Scott Smith	Scott Smith	Brother of owner	Rent disclosure
Emily Johnson	Dietary Consulting Group, LLC	Sister-in-law of owner	Dietician disclosure

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE D - STAFF AND OTHER INFORMATION

1. Total number of employees for last payroll	12.0
2. Number of Minimum Wage Employees	2.0
3. Position Summary	Full Time Equivalent
a. Direct Care	8.50
b. Care Related	0.50
c. Administrative and Operating	1.00
Total Full Time Equivalent *(a. + b. + c.)*	10.00

4. Fringe Benefits Provided

a. Life Insurance		
b. Health Insurance		
c. Retirement Plan		
d. Uniforms		
e. Meals		
f. Other - Describe		
g. Other - Describe		
h. Other - Describe		
i. None	X	

Only use none if no employee benefits are reported on Sch H.

5. Number of vehicles owned or leased by facility	1
6. Number of mortgages on fixed assets	0

	Original Date	Amount	Interest Rate	Amortization Period
a. First Mortgage				
b. Second Mortgage				
c. Third Mortgage				

7. Other rates received

a. Private client rate		25.00
b. Other state or federal rates		0.00
c. Other *(specify)*		0.00

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

Employee's salary exceeds LDH salary limit. Schedule I adjustment is required.

SCHEDULE E - STAFFING PATTERN

Note: List each position separately.

Option 1 - Aides disclosure

Position Title	Avg Hours Per Week	Actual Salary for Cost Report Period	Schedule H (Part & Line Number)
DSW (2 FTEs)	40.00	31,745	A-1
LPN	40.00	15,281	A-2
RN	40.00	51,778	A-3
Soc Service worker	40.00	15,796	A-4
Activity Coordinator	20.00	6,009	A-5
Cook	30.00	12,489	B-2
Asst. Adminstrator	30.00	10,138	C-2
Clerical	10.00	4,285	C-6
Owner/administrator	40.00	120,000	C-1
Driver	30.00	17,664	E-1
Owner	8.00	30,000	C-7

Reflects Part-time status

Option 2 - Aides disclosure

DSW -1	32.00	28,455	A-1
DSW -2	8.00	3,290	A-1

TOTAL	**$**	**346,930**

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE F - BALANCE SHEET

ASSETS

ACCOUNTS	PER BOOKS
Current Assets:	
1. Cash on Hand and in Banks	26,227
2. Accounts Receivable	
3. Notes Receivable	
4. Other Receivables	
5. Less: Allowance for uncollectible Accounts Receivable & Notes Receivable	25
6. Inventory	
7. Prepaid Expenses	
8. Investment	
9. Other *(specify)* :	
10. Total Current Assets	$ 26,252
Fixed Assets:	
11. Land	
12. Buildings	
13. Less: Accumulated Depreciation	
14. Leasehold Improvements	5,656
15. Less: Accumulated Depreciation	(5,656)
16. Fixed Equipment	
17. Less: Accumulated Depreciation	
18. Major Movable Equipment	2,036
19. Less: Accumulated Depreciation	(1,758)
20. Motor Vehicles	16,150
21. Less: Accumulated Depreciation	(13,812)
22. Minor Equipment (non-depreciable)	
23. Total Fixed Assets	$ 2,616
Other Assets:	
24. Investments	
25. Deposits on Leases or Utilities	500
26. Due from Owners/Officers	
27. Dues to Funds	
28. Other *(specify)* :	
29. Total Other Assets	$ 500
30. TOTAL ASSETS *(sum of lines 10, 23 & 29)*	$ 29,368

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE F - BALANCE SHEET

LIABILITIES AND CAPITAL

ACCOUNTS		PER BOOKS
Current Liabilities		
31. Accounts Payable		
32. Notes Payable		92,790
33. Current Portion of Long-term Debt		
34. Salaries-Fees Payable		4,197
35. Payroll Taxes Payable		3,949
36. Deferred Income		
37. Other *(specify)* :	Accrued bonuses	3,974
38. Total Current Liabilities		$ 104,910
Long-Term Liabilities		
39. Mortgages Payable		
40. Notes Payable		
41. Unsecured Loans		
42. Loans from Owners		239,260
43. Total Long-Term Liabilities		$ 239,260
44. TOTAL LIABILITIES *(sum of lines 38 and 43)*		$ 344,170
45. Capital		
(a) Retained Earnings		(381,059)
(b) Capital Stock		100
(c) Other *(specify)*	Additional Paid in Capital	66,157
(d) Other *(specify)*	Intentional error	100
(e) Other *(specify)*		
(f) Other *(specify)*		
(g) Other *(specify)*		
46. Total Capital		$ (314,702)
47. TOTAL LIABILITIES AND CAPITAL *(sum of lines 44 and 46)*		$ 29,468

See page 23 for Validation Edit identifying this error.

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

Adjustments in this column should have corresponding expense adjustment on Sch H

SCHEDULE G - INCOME STATEMENT

		(a) Income per Books	(b) Provider Adjustments (from Schedule I)	(c) Adjusted Balance
Routine Service Income:				
1a	Medicaid - State - Routine	237,510	-	$ 237,510
1b	N/A		-	$ -
2	Other State Revenue - Routine		-	$ -
2a	Health Monitoring Revenue	43,657	-	$ 43,657
2b	Meal Delivery Revenue	798	-	$ 798
3	Private - Routine	354	-	$ 354
4a	Grants - Federal*		-	$ -
4b	Grants - State*		-	$ -
5	Other *(specify)* VA	65,006	-	$ 65,006
6	Total Routine Service Income	347,325	-	$ 347,325
Other Income:				
7	Special expense reimbursement (state clients)		-	$ -
8a	Donations - Restricted		-	$ -
8b	Donations - Unrestricted	150	-	$ 150
9	Sale of Drugs		-	$ -
10	Therapy		-	$ -
11	Sale of Supplies		-	$ -
12	Employee and Guest Meals		-	$ -
13	Interest	225	(225)	$ -
14	Rentals		-	$ -
15	Beauty and Barber Shop		-	$ -
16	Vending Machine		-	$ -
17a	Miscellaneous *(specify)* Garnishment fees	100	(100)	$ -
17b	Miscellaneous *(specify)* Worker's comp refund	500	(500)	$ -

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE G - INCOME STATEMENT

		(a) Income per Books	(b) Provider Adjustments (from Schedule I)	(c) Adjusted Balance
17c	Miscellaneous *(specify)*		-	$ -
17d	Miscellaneous *(specify)*		-	$ -
17e	Miscellaneous *(specify)*		-	$ -
18	Total Other Income	975	(825)	$ 150
19	Total Income *(line 6 and 18)*	348,300	(825)	$ 347,475
	Less Refunds and Allowances**			
20	Medicaid - Refunds and Allowances		-	$ -
21	Other State Revenue - Refunds and Allowances		-	$ -
22	Private - Refunds and Allowances		-	$ -
23	Other *(specify)*		-	$ -
24	Total Refunds and Allowances	-	-	$ -
25	Net Income *(line 19 minus 24)*	348,300	(825)	$ 347,475

*State type grant, period covered; if more than one, provide separate listing.
If grant is continuous or declining, state percentages or amounts.

**Indicate amount reimbursed or credited to LDH (if any).

Column a should agree to the cost report grouping schedule attached to the cost report

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE H - EXPENSES

Expense Classification		(a) Expenses per Books	(b) Provider Adjustments (from Schedule I)	(c) Allowable Expenses
A. Direct Care Costs				
1 Salaries - Aides	Should not include contract workers	31,745	-	$ 31,745
2 Salaries - LPNs		15,281	-	$ 15,281
3 Salaries - RNs		51,778	-	$ 51,778
4 Salaries - Social Services		15,796	-	$ 15,796
5 Salaries - Activities (excl. Act. Dir.)		6,009	-	$ 6,009
6 Payroll Taxes		10,345	-	$ 10,345
7 Employee Benefits		1,500	-	$ 1,500
8 Workers' Compensation		2,002	(299)	$ 1,703
9 Contract - Aides	Should not include salaried personnel		-	$ -
10 Contract - LPNs			-	$ -
11 Contract - RNs			-	$ -
12 Contract - Social Services (MSW)			-	$ -
13 Drugs - OTC & Non-Legend			-	$ -
14 Medical Supplies			-	$ -
15 Medical Waste Disposal			-	$ -
16 a. Recreation/Activity Supplies		912	-	$ 912
b. Other Supplies (specify)	*PPE (gloves, masks)*	501	-	$ 501
17 Allocated Costs - Central Office or Hospital Based			-	$ -
18 a. Miscellaneous (specify)			-	$ -
b. Miscellaneous (specify)			-	$ -
Total Direct Care Costs		**$ 135,869**	**$ (299)**	**$ 135,570**

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE H - EXPENSES

Expense Classification	(a) Expenses per Books	(b) Provider Adjustments (from Schedule I)	(c) Allowable Expenses
B. Care Related Costs			
1 Salaries - Supervisory Staff		-	$ -
2 Salaries - Dietary	12,489	-	$ 12,489
3 Payroll Taxes	1,195	-	$ 1,195
4 Employee Benefits	500	-	$ 500
5 Workers' Compensation	270	(40)	$ 230
6 Contract Employees - Dietary		-	$ -
7 Consultant Fees			
a. Activities Consultant Fees		-	$ -
b. Nursing Consultant Fees		-	$ -
c. Pharmacy Consultant Fees		-	$ -
d. Social Worker Consultant Fees		-	$ -
e. Therapists Consultant Fees		-	$ -
8 Food	6,783	-	$ 6,783
9 Food-Supplements	12	-	$ 12
10 Supplies	715	-	$ 715
11 Allocated Costs - Central Office or Hospital Based		-	$ -
12 Miscellaneous			
a. Miscellaneous (specify)		-	$ -
b. Miscellaneous (specify)		-	$ -
Total Care Related Costs	**$ 21,964**	**$ (40)**	**$ 21,924**

Should not include contract workers

Consultants only - Not contract employees

Do not report dietary supplies here. Report on Line C19

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE H - EXPENSES

Expense Classification	(a) Expenses per Books	(b) Provider Adjustments (from Schedule I)	(c) Allowable Expenses
C. Administrative and Operating Costs			
1 Salaries and Wages - Administrator	120,000	(14,794)	$ 105,206
2 Salaries and Wages - Asst Administrator	10,138	-	$ 10,138
3 Salaries and Wages - Housekeeping		-	$ -
4 Salaries and Wages - Laundry		-	$ -
5 Salaries and Wages - Maintenance		-	$ -
6 Salaries and Wages - Other Administrative	4,285	(100)	$ 4,185
7 Salaries and Wages - Owner or Owner/Admin.	30,000	(8,959)	$ 21,041
8 Payroll Taxes	2,867	(1,059)	$ 1,808
9 Employee Benefits	3,500	(396)	$ 3,104
10 Workers' Compensation	693	(103)	$ 590
11 Contract - Housekeeping		-	$ -
12 Contract - Laundry		-	$ -
13 Contract - Maintenance		-	$ -
14 Consultant Fees - Dietician	570	-	$ 570
Administrative & Operating Subtotal	$ 172,053	$ (25,411)	$ 146,642

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE H - EXPENSES

Expense Classification		(a) Expenses per Books	(b) Provider Adjustments (from Schedule I)	(c) Allowable Expenses
15 Accounting and Billing Fees		1,966	-	$ 1,966
16 Amortization Expense Non-Capital			-	$ -
17 Bank Service Charge			-	$ -
18 Board of Directors' Fees			-	
19 Dietary Supplies			-	$ -
20 Dues			-	$ -
21 Educational Seminars and Training			-	$ -
22 Housekeeping Supplies			-	$ -
23 Insurance - Professional Liability and Other		12,050	-	$ 12,050
24 Interest on Non-Capital		7,800	-	$ 7,800
25 Laundry and Linen Supplies			-	$ -
26 Legal Fees			-	$ -
27 Information Technology Supplies, Services, and Software			-	$ -
28 Management Fees (Unrelated)			-	$ -
29 Office Supplies and Subscriptions		2,895	-	$ 2,895
30 Postage		105	-	$ 105
31 Repairs and Maintenance		4,536	-	$ 4,536
32 Taxes and License		875	-	$ 875
33 Telephone & Communications		8,594	-	$ 8,594
34 Travel			-	$ -
35 Utilities		4,766	-	$ 4,766
36 Allocated Costs - Cantal Office or Hospital Based			-	$ -
37 Maintenance Supplies		498	-	$ 498
38 Advertising		610	(250)	$ 360
39 Miscellaneous				
a. Miscellaneous (specify)	*Security*	1,013	-	$ 1,013
b. Miscellaneous (specify)	*Background checks*	1,250	-	$ 1,250
c. Miscellaneous (specify)	*Donations*	1,000	(1,000)	$ -
d. Miscellaneous (specify)			-	$ -
e. Miscellaneous (specify)			-	$ -
Total Administrative and Operating Costs		**$ 220,011**	**$ (26,661)**	**$ 193,350**

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE H - EXPENSES

Expense Classification	(a) Expenses per Books	(b) Provider Adjustments (from Schedule I)	(c) Allowable Expenses
D. Property and Equipment			
1 Amortization Expense - Capital		-	$ -
2 Depreciation Expense - (Provide detailed schedules)			
a. Depreciation - Buildings		500	$ 500
b. Depreciation - Furniture & Equipment	11	-	$ 11
c. Depreciation - Leasehold Improvements	3,320	-	$ 3,320
3 Interest Expense - Capital	602	(225)	$ 377
4 Property Insurance		3,350	$ 3,350
5 Property Taxes		-	$ -
6 Rent - Building	12,000	(12,000)	$ -
7 Rent - Furniture & Equipment		-	$ -
8 Allocated Costs - Cantal Office or Hospital Based		-	$ -
9 Miscellaneous			
a. Miscellaneous (specify)		-	$ -
b. Miscellaneous (specify)		-	$ -
Total Property & Equipment	**$ 15,933**	**$ (8,375)**	**$ 7,558**
E. Transportation Expense			
1 Salaries and Wages - Drivers	17,664	-	$ 17,664
2 Payroll Taxes - Transportation	1,657	-	$ 1,657
3 Employee Benefits - Transportation	500	-	$ 500
4 Workers Compensation - Transportation	385	(58)	$ 327
5 Non-Emergency Medical Transportation		-	$ -
6 Interest Expense - Motor Vehicles		-	$ -
7 Property Insurance - Motor Vehicles		-	$ -
8 Vehicle Expenses (Gas, Oil, etc..)	9,120	-	$ 9,120
9 Depreciation - Motor Vehicles	1,730	-	$ 1,730
10 Auto Lease		-	$ -
Total Transportation Expense	**$ 31,056**	**$ (58)**	**$ 30,998**
Sum of Sections A, B, C, D, and E	**$ 424,833**	**$ (35,433)**	**$ 389,400**

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

Explanation should reflect the reason for the adjustment, not just the account title

SCHEDULE I - EXPLANATION FOR ADJUSTMENTS

Adj.	Schedule	Part	Line	Column	Explanation for Adjustment	Provider Adjustment
1	G - Income Stmt		13 Interest	Total	To offset Interest Income against related exp	(225)
1	H - Expenses	D	3 Interest - Mortgage on Building or Equipment	Total	To offset Interest Income against related exp	(225)
2	G - Income Stmt		17a Miscellaneous (specify)	Total	To offset misc income against related exp	(100)
2	H - Expenses	C	6 Salaries and Wages - Other Administrative	Total	To offset misc income against related exp	(100)
3	H - Expenses	C	38 Advertising	Total	To remove promotional advertising	(250)
4	H - Expenses	D	6 Rent - Building	Total	To remove related party rent	(12,000)
4	H - Expenses	D	2a. Depreciation - Buildings	Total	To add actual related party building expenses	500
4	H - Expenses	D	4 Property Insurance	Total	To add actual related party building expenses	2,100
4	H - Expenses	D	4 Property Insurance	Total	To add actual related party building expenses	1,250
5	H - Expenses	C	39c. Miscellaneous	Total	To remove donations	(1,000)
6	G - Income Stmt		17b Miscellaneous (specify)	Total	To offset W/C Income against related exp	(500)
6	H - Expenses	A	8 Workers' Compensation	Total	To offset W/C Income against related exp	(299)
6	H - Expenses	B	5 Workers' Compensation	Total	To offset W/C Income against related exp	(40)
6	H - Expenses	C	10 Workers' Compensation	Total	To offset W/C Income against related exp	(103)
6	H - Expenses	E	4 Workers Compensation - Transportation	Total	To offset W/C Income against related exp	(58)
7	H - Expenses	C	1 Salaries and Wages - Administrator	Total	To adjust salary to LDH salary limit	(14,794)
7	H - Expenses	C	7 Salaries and Wages - Owner or Owner/Admin.	Total	To adjust salary to LDH salary limit	(8,959)
7	H - Expenses	C	8 Payroll Taxes	Total	To adjust payroll taxes related to salary limit adjustments	(1,059)
7	H - Expenses	C	9 Employee Benefits	Total	To adjust payroll taxes related to salary limit adjustments	(396)

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE I - EXPLANATION FOR ADJUSTMENTS

Adj.	Schedule	Part	Line	Column	Explanation for Adjustment	Provider Adjustment
					Incorrect examples of explanations	
1	G - Income Stmt		13 Interest	Total	Offset	
1	H - Expenses	D	3 Interest - Mortgage on Building or Equipment	Total	Interest expense	
2	G - Income Stmt		17a Miscellaneous (specify)	Total	Offset	
2	H - Expenses	C	6 Salaries and Wages - Other Administrative	Total	Offset	
3	H - Expenses	C	38 Advertising	Total	Advertising	
4	H - Expenses	D	6 Rent - Building	Total	RP rent	
4	H - Expenses	D	2a. Depreciation - Buildings	Total	Depreciation	
4	H - Expenses	D	4 Property Insurance	Total	Insurance	
4	H - Expenses	D	5 Property Taxes	Total	Prop taxes	

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE I - EXPLANATION FOR ADJUSTMENTS

Adj.	Schedule	Part	Line	Column	Explanation for Adjustment	Provider Adjustment

INCOME TOTALS	**(825)**
EXPENSE TOTALS	**(35,433)**
GRAND TOTALS (Includes Statistics)	**(36,258)**

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE J - SUBMITTED CALCULATION OF COSTS PER QUARTER HOUR BY CATEGORY

Expense Classification	Allowable Expenses (a)	Divided by Total Client Quarter Hour Increments (b)	Allowable Cost per Quarter Hour Increment (c)
A. Direct Care Costs	135,570 (from Schedule H, Part A, Total)	124,691 (from Sched. B, #9 Total)	$ 1.09 (Column a Divided by b)
B. Care Related Costs	21,924 (from Schedule H, Part B, Total)	124,691 (from Sched. B, #9 Total)	$ 0.18 (Column a Divided by b)
C. Administrative and Operating Costs	193,350 (from Schedule H, Part C, Total)	124,691 (from Sched. B, #9 Total)	$ 1.55 (Column a Divided by b)
D. Property & Equipment	7,558 (from Schedule H, Part D, Total)	124,691 (from Sched. B, #9 Total)	$ 0.06 (Column a Divided by b)
E. Transportation Costs	30,998 (from Schedule H, Part E, Total)	124,691 (from Sched. B, #9 Total)	$ 0.25 (Column a Divided by b)
Total Allowable Costs	$ 389,400		

Quarter Hour Increments must agree to Schedule B, Line 8a.

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE K - Direct Care Cost Settlement

Provider's As-Submitted Data

ADHC Direct Care Floor			(a) ADHC Medicaid Quarter Hour Increments		(b) ADHC Direct Care Rate Component		(c) ADHC Medicaid Direct Care Revenue	(d) ADHC Medicaid Direct Care Revenue 70%
1a. 7/1/2023	-	6/30/2024	95,066	x	$ 2.08	=	$ 197,737	$ 138,416
1b. n/a	-	n/a			$ -	=	$ -	$ -
1c. n/a	-	n/a			$ -	=	$ -	$ -
			95,066				$ 197,737	$ 138,416

Health Status Monitoring Direct Care Floor			(a) HSM Medicaid Quarter Hour Increments		(b) HSM Direct Care Rate Component		(c) HSM Medicaid Direct Care Revenue
2.			29,504	x	$ 0.15	=	$ 4,426
3.	**Total Direct Care Floor (Line 1, Col. (d) plus Line 2, Col. (c))**						$ 142,842

	(a) ADHC & HSM Medicaid Quarter Hour Increments		(b) Direct Care Costs Per Quarter Hour Increment		(c) ADHC & HSM Medicaid Direct Care Allowable Cost
4. Actual Cost	124,570	x	$ 1.09	=	$ 135,781
5. Due to State	Subtract Line 4, Col. (c) from Line 3 (if less than zero, enter zero)				$ 7,061

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

SCHEDULE M - Certification Statement by Owner, Officer, or Administrator of Facility

I, Sue Smith (Name), Adminstrator (Administrative Title)

of XYZ ADHC, Inc. (Name of Facility)

Baton Rouge (City), Louisiana (State) do certify that I have examined the attached report for the cost report period beginning 7/1/2023 and ending 6/30/2024 and to the best of my knowledge and belief, it is a true and correct statement of the information required.

Signature of Authorized Representative of Facility — Date: 9/1/2024

Title: Administrator

Total ADHC Quarter Hour Increments:	124,691	Total Medicaid Direct Care Revenue:	$ 197,737
Total Allowable Expenses:	$ 389,400	Amount Due To State	$ 7,061

Comments:

Signature of Preparer — Date

Name of Preparer

VENDOR NUMBER: 12345
FACILITY NAME: XYZ ADHC, Inc.
COST REPORT PERIOD: 7/1/2023 TO 6/30/2024

Validation Edits

Comparison #1		Comparison #2		Difference
Total Assets *(Sched. F - Balance Sheet, Line 30)*	$ 29,368	Total Liabilities & Capital *(Sched. F - Balance Sheet, Line 47)*	$ 29,468	$ (100)
Total Client Days *(Sched. B - Stats, Line 6)*	2,918	Total Client Days Available *(Sched. B - Stats, Line 4)*	10,000	
Director's Fees Amount *(Sched. H - Expenses, Pt. C, Line 18, Column a)*	$ -	Director's Fees Adjustment Amount *(Sched. H - Expenses, Pt. C, Line 18, Columns b & c)*	$ -	$ -
Total Client Adjustments Posted	$ (36,258)	Total Client Adjustments Entered	$ (36,258)	$ -
Total LDH Adjustments Posted	$ -	Total LDH Adjustments Entered	$ -	$ -
Schedule A Properly Completed				
Schedule B Properly Completed				
Schedule C Properly Completed				
Schedule D Properly Completed				

**Amounts in Difference column should be zero.

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Louisiana ADHC Cost Report Template Instructions

ADHC Version 3.6 7/3/2024

For Versions of Excel prior to 2007, there is a toolbar that includes buttons for Auditor, Add Row, Delete Extra Rows, Print, and Instructions that should show above, if the macros have been properly enabled.

For Office 2007 and 2016 (new version), Auditor, Add Row, Delete Extra Rows, Print, and Instructions toolbar buttons will show under the "Add-Ins" menu if the macros have been properly enabled.

Macro Security Change Instructions (needed to run template with macros enabled)

For Microsoft Excel 2007 or newer:

You can change macro security settings in the Trust Center, unless a system administrator in your organization has changed the default settings to prevent you from changing the settings.

On the **Developer** tab, in the **Code** group, click **Macro Security**.

Tip If the **Developer** tab is not displayed, click the **Microsoft Office Button** (upper left hand corner of the screen), click **Excel Options,** and then in the **Popular category,** under **Top options** for working with Excel, click **Show Developer tab in the Ribbon.**

In the **Macro Settings** category, under **Macro Settings**, click the option that enables all macros (low security) or the option

that allows you to disable macros with notification (if the notification option is chosen, you will see a "SECURITY WARNING" message above the formula bar - you must click the Options… button to enable the macros after you open the file).

For Older Versions of Microsoft Excel:

Click **"Tools"** on the Menu and then click **"Macro" – "Security"**. Select **"Low" or "Medium"** security. Then reopen the cost report template file.

General

Custom Toolbar Buttons:

- Auditor Toolbar Button - for use by P&N only.
- Add and Delete Extra Rows - used on adjustment report schedule, related parties, and staffing schedules.
- Print - used to print package.
- Instructions - used to access this page.

All lines and schedules should be completed by the provider. If the appropriate answer is zero or not applicable, the provider must report "0" or "NA". No lines should be left blank.

All dollar amounts should be rounded to the nearest dollar. Only per diem amounts reported on Schedules D and K. should include cents. All per diems should be rounded to the nearest penny.

All costs reported on the cost report should be in accordance with the Louisiana ADHC Standards for Payment and the Federal CMS Publication 15. The accrual basis of accounting is required. Amount per books should be adjusted to the accrual basis prior to completion of the cost report. The cost report should reflect all year-end closing entries.

To access the CMS Publication 15 go to the following web-site:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html

Use the TAB key to move throughout the forms to ensure no fields are skipped. Use drop-down arrows to scroll and select items in fields that contain lists.

Schedule A - Facility Info

Identifying Information

Report in the spaces provided the corporate and facility name, address, also 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

Under type of control, select the applicable control type from drop-down menu (only one option should be selected). If "Other" is selected as the type of control, an additional box will appear and a description must be entered.

Schedule B - Stats

Statistical and Other Data

1. Enter total number of licensed capacity at beginning of the period.

2. Enter total number of 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.

6. Enter the client quarter hour increments in the appropriate category. (Example: 0.25 hours = 1 quarter hour increment)
   Note: For Line 8d, the Health Monitoring Billing Units (Per Diem units) should be reported. Line 8e will calculate the quarter hour increments related to Health Monitoring. Please use billed units if provider's internal records of actual services were not maintained.
7. Enter the total Home Delivered Meals at the end of the period on line 10.
   Note: Please use billed units if provider's internal records of actual services were not maintained.

Schedule C - Related Parties

Ownership and Related Organization

1. List all owners with 5% interest or more and/or members of the Board of Directors and key officers even if they receive no compensation, and list all relatives of owners, Board Members and key officers employed by the provider.

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 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.

4. If the facility has related party transactions as defined in the Provider Reimbursement Manual, Part 1, complete a. and b.

Schedule D - Misc

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 -- Next to each applicable benefit, select "X" from the drop down menu. If “Other” is selected, an additional box will appear and a description must be entered.

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.

Schedule E - Staffing

Staffing Pattern

Complete staffing pattern for each position and indicate the cost report line item number. Average hours per week should be calculated as total annual hours divided by 52 weeks. Actual salary for the cost report period should agree to salaries reported on Schedule H, column (a).

Schedule F - Balance Sheet

Balance Sheet-Assets
Enter appropriate balance sheet asset accounts per books as of the end of the cost report period.

Balance Sheet-Liabilities
Enter appropriate balance sheet liability and equity accounts per books as of the end of the cost report period.

Schedule G - Income Statement

Income Statement

Enter appropriate income account balances per books as of the end of the period in the first column. Enter any income offset adjustments in second column using Schedule I. The adjusted balance is calculated in the last column. Any grants reported on Line 4 and any miscellaneous income reported on Line 17 should be specified.
Note: All miscellaneous and other amounts must be specified in the boxes provided next to Column A.

Schedule H - Expenses

Part A, 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 using Schedule I.

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).
Note: All miscellaneous and other amounts must be specified in the boxes provided next to Column A.

Part B, 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 using Schedule I.

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).
Note: All miscellaneous and other amounts must be specified in the boxes provided next to Column A.

Part C, 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 using Schedule I.

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).
Note: All miscellaneous and other amounts must be specified in the boxes provided next to Column A.

Part D, 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 using Schedule I.

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).
Note: All miscellaneous and other amounts must be specified in the boxes provided next to Column A.
A copy of the depreciation schedule must be attached for each line item reporting depreciation expense.

Part E, Transportation 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 using Schedule I.

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 E, column (a).
Note: All miscellaneous and other amounts must be specified in the boxes provided next to Column A.
A copy of the depreciation schedule must be attached for each line item reporting depreciation expense.

PHE Services - Health Status Monitoring and Home Delivered Meals

Expenses related to Health Status Monitoring and Home Delivered Meals should be reported in Sections A, B and E as appropriate.

Schedule I - Adjustments

Schedule of Adjustments

Enter the information for each cost report adjustment. Explanations should be specific as to the nature of the adjustment. Types of adjustments include offsets of other income, removal of non-allowable expenses, and related party transaction adjustments to actual cost.

Schedule J - Cost Per Quarter Hour

Note: No provider input is necessary on this schedule.

Schedule K - Settlement

Direct Care Cost Settlement

1. Multiply the ADHC Direct Care Rate Component (Column (b)) by the number of ADHC Medicaid Quarter Hour Increments (Column (a)) (reported on Sch B, Line 8a) to calculate ADHC Direct Care Revenue (Column (c)). Multiply ADHC Medicaid Direct Care Revenue Column (c) by 70%, enter amount in Column (d). This amount is used for the cost settlement calculation.

2. Multiple the Health Status Monitoring Direct Care Rate Component (Column (b)) by the number of Health Status Monitoring Quarter Hour Increments (Column (a)) (reported on Sch B, Line 8e) to calculate Health Status Monitoring Direct Care Revenue (Column (c)).

3. Sum Line 1, column (d) and Line 2, column (c) to calculate the Total Direct Care Floor (ADHC and HSM).

4. Multiply ADHC and HSM Medicaid Quarter Hour Increments Column (a) (reported on Sch B, Lines 8a and 8e) times the Direct Care cost per Quarter Hour Increment from Sch J, Line A, Column (c) to calculate ADHC and HSM Medicaid Direct Care Allowable Costs, enter in Column (c).

5. Subtract Line 4, Col. (c) from Line 3 to calculate the amount Due to State. (If amount is less than "0", enter "0".)

If calculation shows money due the Department of Health DO NOT remit payment with the cost report. Provider will be notified of amount due after the Desk Review / Audit.

Schedule M - Certification

Certification Statement

This page must be completed, signed (original signature – no stamps) and dated by the Representative of the facility and the person preparing the cost report.

Validation Edits (or checks) are used to check the accuracy of the cost report.

Please note that having no exceptions when running the "edits" does not guarantee that the cost report is correct.
On the other hand, having an exception does not always mean that you have an error.

Follow the filing instructions on the cover page of the cost report.

To receive official reimbursement notices and software releases, email:
LACostReports@mslc.com
Please include the name of the template and your provider name.

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3. The other operational cost rate component will be calculated in the following manner.

a. Capital expense, transportation expense, other direct non-labor expense, and other overhead expense allocated to reimbursable assistance services will be collected from provider cost reports.

b. Capital expense, transportation expense, supplies, and other direct non-labor expense, and other overhead expense, on an individual cost report basis, will be divided by the cost report direct service wage and contract labor expense for reimbursable assistance services to calculate other operational costs as a percentage of labor costs.

c. The individual cost report other operational cost percentages will be aggregated for all applicable filed cost reports, outliers will be removed, and a simple average statewide other operational cost percentage will be determined.

d. The simple average other operational cost percentage will be multiplied by the blended direct service worker labor rate to calculate the other operational cost rate component.

4. The calculated department reimbursement rates will be adjusted to a one quarter hour unit of service by dividing the hourly adjusted staff cost rate component and the hourly other operational cost rate component totals by four.

5. The department will be solely responsible for determining the sufficiency of the current reimbursement rates during the rate validation process. Any reimbursement rate change deemed necessary due to rate validation process will be subject to legislative budgetary appropriation restrictions prior to implementation.

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, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1112 (August 2021).

Subchapter B. Adult Day Health Care Providers

§707. General Provisions

A. The Department of Health (LDH) establishes reimbursement methodologies and cost reporting requirements for Adult Day Health Care (ADHC) providers of home and community-based waiver programs.

B. ADHC providers in the following waiver programs shall be required to submit cost reports:

1. Adult Day Health Care (ADHC) Waiver;

2. Community Choices Waiver; and

3. Residential Options Waiver (ROW).

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, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1113 (August 2021).

§709. Rate Methodology

A. Adult day health care providers shall be reimbursed a per quarter hour 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 waiver participants by ensuring that direct care services are provided at an acceptable level while fairly reimbursing the providers.

B. Reimbursement shall not be made for ADHC waiver services provided under the waivers prior to the department's approval of the POC.

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, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1114 (August 2021).

§711. Cost Reporting

A. Cost Centers Components

1. Direct Care Costs. This component reimburses for in-house and contractual direct care staffing, social services, and activities (excluding the activities director) and fringe benefits and direct care supplies.

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

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

a. utilities;

b. accounting;

c. dietary supplies;

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, excluding property costs related to participant transportation.

5. Transportation. This component reimburses for in-house and contractual driver salaries and related benefits, non-emergency medical transportation, vehicle maintenance, and supply expense, motor vehicle depreciation, interest expense related to vehicles, vehicle insurance, and auto leases.

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

1. When a provider ceases to participate as an ADHC provider the provider must file a cost report covering a period under this program up to the effective date of cessation of participation in the program. Depending on the circumstances involved in the preparation of the provider's final cost report, the provider may file the cost report for a period of not less than one month or not more than 13 months.

C. The cost reporting forms and instructions developed by the Bureau must be used by all ADHC centers 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 also. 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.

D. Annual Reporting. Cost reports are to be filed on or before the last day of September following the close of the cost 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 with one copy of the following documents:

1. a cost report grouping schedule. This schedule should include all trial balance accounts grouped by cost report line item. All subtotals should agree to a specific line item on the cost report. This grouping schedule should be done for the balance sheet, income statement, and expenses;

2. a depreciation schedule. The depreciation schedule which reconciles to the depreciation expense reported on the cost report must be submitted. If the center files a home office cost report, copies of the home office depreciation schedules must also be submitted with the home office cost report. All hospital based centers must submit a copy 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 and a copy of contracts for managed services, if applicable;

6. for management services provided by a related party or home office, a description of the basis used to allocate the costs to providers in the group and to non-provider activities and copies of the cost allocation worksheet, if applicable. Costs of related management/home offices must be reported on a separate cost report that includes an allocation schedule; and

7. all allocation worksheets must be submitted by hospital-based centers. The Medicare worksheets that must be attached by centers 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 1; and

g. B-1.

E. Each copy of the cost report must have the original signatures of an officer or center 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.

F. 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 for which requested information is not submitted.

G. Accounting Basis. The cost report must be prepared on the accrual basis of accounting. If a center 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 appropriate recordation of costs in the applicable cost reporting 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 appropriate cost reporting period.

H. 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 center 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.

I. Attendance Records

1. Attendance data reported on the cost report must be supportable by daily attendance records. Such information must be adequate and available for auditing.

2. Daily attendance records should include the time of each participant's arrival and departure from the center. The attendance records should document the presence or absence of each participant on each day the center is open. The center's attendance records should document all admissions and discharges on the attendance records. Attendance records should be kept for all participants that attend the adult day center. This includes Medicaid, Veteran's Administration, insurance, private, waiver, and other participants. The attendance of all participants should be documented regardless of whether a payment is received on behalf of the participant. Supporting documentation such as admission documents, discharge summaries, nurse's progress notes, sign-in/out logs, etc. should be maintained to support services provided to each participant.

J. Employee Record

1. the provider shall retain written verification of hours worked by individual employees:

a. records may be sign-in sheets or time cards, but shall indicate the date and hours worked;

b. records shall include all employees even on a contractual or consultant basis;

2. verification of employee orientation and in-service training; and

3. verification of the employee's communicable disease screening.

K. Billing Records

1. The provider shall maintain billing records in accordance with recognized fiscal and accounting procedures. Individual records shall be maintained for each participant. These records shall meet the following criteria.

a. Records shall clearly detail each charge and each payment made on behalf of the participant.

b. Records shall be current and shall clearly reveal to whom charges were made and for whom payments were received.

c. Records shall itemize each billing entry.

d. Records shall show the amount of each payment received and the date received.

2. The provider shall maintain supporting fiscal documents and other records necessary to ensure that claims are made in accordance with federal and state requirements.

L. Non-Acceptable 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.

M. Exceptions. Limited exceptions to the cost report filing 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, the provider 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. If the center has been purchased or established during the reporting period, a partial year cost report may be filed in lieu of the required 12-month report.

2. 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.

N. Delinquent Cost Report. When an ADHC provider fails to submit a cost report by the last day of September following the close of the cost reporting period, a penalty of 5 percent of the monthly payment for the first month and a

progressive penalty of 5 percent of the monthly payment for each succeeding month may be levied and withheld from the ADHC provider's payment for each month that the cost report is due, not extended and not received. The penalty is non-refundable and not subject to an administrative appeal.

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, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1114 (August 2021).

§713. Cost Categories Included in the 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 participant 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 participants.

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 participants.

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 center employees.

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

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

14. Drugs, Over-the-Counter and Non-Legend—cost of over-the-counter and non-legend drugs provided by the center to its participants. This is for drugs not covered by Medicaid.

15. Medical Supplies—cost of participant-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. Recreational Supplies, DC—cost of items used in the recreational activities of the center.

18. Other Supplies, DC—cost of items used in the direct care of participants which are not participant-specific such as prep supplies, alcohol pads, betadine solution in bulk, tongue depressors, cotton balls, thermometers, blood pressure cuffs and under-pads and diapers (reusable and disposable).

19. 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.

20. Miscellaneous, DC—costs incurred in providing direct care services that cannot be assigned to any other direct care line item on the cost report.

21. Total Direct Care Costs—sum of the above line items.

B. Care Related (CR) 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. Contract, Dietary—cost of dietary services, and personnel hired through contract that are not employees of the center.

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

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

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

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

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

14. Food, Raw—cost of food products used to provide meals and snacks to participants. 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 participants of the center. 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. Miscellaneous, CR—costs incurred in providing care related care services that cannot be assigned to any other care related line item on the cost report.

19. 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 centers must attach a schedule of the administrator's salary before allocation, the allocation method, and the amount allocated to the nursing center.

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

7. Salaries, Owner or Owner/Administrator—gross salaries of all owners of the center that are paid through the center.

8. 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.

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

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

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

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

13. Contract, Housekeeping—cost of housekeeping services and personnel hired through contract that are not employees of the center.

14. Contract, Laundry—cost of laundry services and personnel hired through contract that are not employees of the center.

15. Contract, Maintenance—cost of maintenance services and persons hired through contract that are not employees of the center.

16. Consultant Fees, Dietician—fees paid to consulting registered dieticians.

17. 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 center and other related services excluding personal tax planning and personal tax return preparation.

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

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

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

21. Dues—dues to one organization are allowable.

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

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

24. Insurance, Professional Liability and Other—includes the costs of insuring the center against injury and malpractice claims.

25. Interest expense, non-capital interest paid on short term borrowing for center operations.

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

27. Legal Fees—only actual and reasonable attorney fees incurred for non-litigation legal services related to participant care are allowed.

28. Linen Supplies—cost of sheets, blankets, pillows, and gowns.

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

30. 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, center letterhead and billing forms;

c. cost of subscribing to newspapers, magazines and periodicals.

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

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

33. Taxes and Licenses—the cost of taxes and licenses paid that are not included on any other line of the cost report. This includes tags for vehicles, licenses for center staff (including nurse aide re-certifications) and buildings.

34. Telephone and Communications—cost of telephone services, internet and fax services.

35. 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 center business. Commuting expenses and travel allowances are not allowable.

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

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

38. Advertising–costs of employment advertising and soliciting bids. Costs related to promotional advertising are not allowable.

39. Maintenance Supplies-supplies used to repair and maintain the center building, furniture and equipment except vehicles.

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

41. Total administrative and operating costs.

D. Property and Equipment

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

4. Property Insurance—cost of fire and casualty insurance on center buildings, and equipment, excluding vehicles. HCBS providers that share owned or leased space with other programs, Medicaid or private, should allocate building costs such as property insurance, property taxes, depreciation, etc. based on documented square footage used by each program.

5. Property Taxes—taxes levied on the center's buildings and equipment. HCBS providers that share owned or leased space with other programs, Medicaid or private, should allocate building costs such as property insurance,

property taxes, depreciation, etc. based on documented square footage used by each program.

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

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

8. 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.

9. Miscellaneous, Property—any capital costs related to the center that cannot be assigned to any other property and equipment line item on the cost report.

10. Total property and equipment.

E. Transportation Costs

1. Salaries, Drivers—gross salaries of personnel involved in transporting participants to and from the center.

2. Payroll Taxes, Transportation—the cost of the employer's portion of Federal Insurance Contribution Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Tax Act (SUTA), and Medicare tax for drivers.

3. Employee Benefits, Transportation—the cost of group insurance, pensions, uniform allowances, and other employee benefits related to drivers.

4. Workers' Compensation, Transportation—the cost of workers' compensation insurance for drivers.

5. Non-Emergency Medical Transportation—the cost of purchased non-emergency medical transportation services including, but not limited to:

a. payments to employees for use of their personal vehicle(s);

b. ambulance companies; and

c. other transportation companies for transporting participants of the center.

6. Interest Expenses, Vehicles—interest paid or accrued on loans used to purchase vehicles.

7. Property Insurance, Vehicles—the cost of vehicle insurance.

8. Vehicle Expenses—vehicle maintenance and supplies, including gas and oil.

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

10. Total Transportation Costs.

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, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1116 (August 2021).

§715. Allowable Costs

EDITOR'S NOTE: The provisions of this Section were previously located in LAC 50:XXI.2907.

A. 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.

1. These general cost principles include determining whether the cost is:

a. ordinary, necessary, and related to the delivery of care;

b. 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

c. for goods or services actually provided to the center.

B. Through the desk review and/or audit process, adjustments and/or disallowances may be made to a provider's reported costs. The Medicare Provider Reimbursement Manual is the final authority for allowable costs unless the Department has set a more restrictive policy.

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, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1119 (August 2021).

§717. Non-allowable Costs

EDITOR'S NOTE: The provisions of this Section were previously located in LAC 50:XXI.2909.

A. Costs that are not based on the reasonable cost of services covered under Medicare and are not related to the care of participants are considered non-allowable costs.

B. Reasonable cost does not include the following:

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

C. General non-allowable costs:

1. services for which Medicaid participants are charged a fee;

2. depreciation of non-participant care assets;

3. services that are reimbursable by other state or federally funded programs;

4. goods or services unrelated to participant care;

5. unreasonable costs.

D. Specific non-allowable costs (this is not an all-inclusive listing):

1. advertising—costs of advertising to the general public that seeks to increase participant 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 participants;

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. non-participant entertainment;

15. non-Medicaid related care costs—costs allocated to portions of a center 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, LDH, the Internal Revenue Service or the state Tax Commission;

19. insufficient funds charges;

20. personal comfort items; and

21. 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, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1119 (August 2021).

§719. Audits

EDITOR'S NOTE: The provisions of this Section were previously located in LAC 50:XXI.2911.

A. Each provider shall file an annual center cost report and, if applicable, a central office cost report.

B. The provider shall be subject to financial and compliance audits.

C. All providers who elect to participate in the Medicaid program shall be subject to audit by state or federal regulators or their designees. Audit selection shall be at the discretion of the department.

1. The department conducts desk reviews of all of the cost reports received and also conducts on-site audits of provider cost reports.

2. The records necessary to verify information submitted to the department on Medicaid cost reports, including related-party transactions, and other business activities engaged in by the provider, must be accessible to the department's audit staff.

D. In addition to the adjustments made during desk reviews and on-site audits, the department may exclude or adjust certain expenses in the cost report data base in order to base rates on the reasonable and necessary costs that an economical and efficient provider must incur.

E. The center shall retain such records or files as required by the department and shall have them available for inspection for five years from the date of service or until all audit exceptions are resolved, whichever period is longer.

F. If a center's audit results in repeat findings and adjustments, the department may:

1. withhold provider's payments until the center submits documentation that the non-compliance has been resolved;

2. exclude the provider's cost from the database used for rate setting purposes; and

3. impose civil monetary penalties until the center submits documentation that the non-compliance has been resolved.

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

H. Provider payments may also be withheld under the following conditions:

1. a center fails to submit corrective action plans in response to financial and compliance audit findings within 15 days after receiving the notification letter from the department; or

2. a center fails to respond satisfactorily to the department's request for information within 15 days after receiving the department's notification letter.

I. The provider shall cooperate with the audit process by:

1. promptly providing all documents needed for review;

2. providing adequate space for uninterrupted review of records;

3. making persons responsible for center records and cost report preparation available during the audit;

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

5. insuring that complete information is maintained in participant's records;

6. developing a plan of correction for areas of noncompliance with state and federal regulations immediately after the exit conference time limit of 30 calendar days.

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, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1120 (August 2021).

§721. Exclusions from the Database

EDITOR'S NOTE: The provisions of this Section were previously located in LAC 50:XXI.2913.

A. The following providers shall be excluded from the database used to calculate the rates:

1. providers with disclaimed audits; and

2. providers with cost reports for periods other than a 12-month period.

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, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1120 (August 2021).

§723. Provider Reimbursement

A. Cost Determination Definitions

Base Rate—calculated in accordance with §723.B.5, plus any base rate adjustments granted in accordance with §723.B.7 which are in effect at the time of calculation of new rates or adjustments.

Index Factor—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).

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.

Rate Component—the rate is the summation of the following:

a. direct care;

b. care related costs;

c. administrative and operating costs;

d. property costs; and

e. transportation costs.

B. Rate Determination

1. The base rate is calculated based on the most recent audited or desk reviewed cost for all ADHC providers filing acceptable full year cost reports. The rates are based on cost components appropriate for an economic and efficient ADHC providing quality service. The participant per quarter hour rates represent the best judgment of the state to provide reasonable and adequate reimbursement required to cover the costs of economic and efficient ADHC.

2. For rate periods between rebasing, the rates will be trended forward using the index factor contingent upon appropriation by the legislature.

3. The median costs for each component are multiplied in accordance with §723.B.4 then by the appropriate index 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 index factors, unless they are adjusted as provided in §723.B.6 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 allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, 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 by dividing the value of the consumer price index-medical services (south region) index for December of the year preceding the rate year by the value of the index for the December of the year preceding the cost report year. The direct care rate component shall be set at 115 percent of the inflated median.

b. Care Related Cost Component. Care related allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, 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 by the value of the consumer price index-all items (south region) index for December of the year preceding the rate year by the value of the index for the December of the year preceding the cost report year. The care related rate component shall be set at 105 percent of the inflated median.

c. Administrative and Operating Cost Component. Administrative and operating allowable quarter hour cost from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, 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 (south region) index for December of the year preceding 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. The property allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, 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. This will be the rate component. Inflation will not be added to property costs.

e. Transportation Cost Component. The transportation allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, will be calculated on a provider by provider basis. Should a provider not have filed an acceptable full year cost report, the provider's transportation cost will be reimbursed as follows.

i. New provider, as described in §723.E.1, will be reimbursed in an amount equal to the statewide allowable quarter hour median transportation costs.

(a). In order to calculate the statewide allowable quarter hour median transportation costs, all acceptable full year cost reports, except those for which an audit disclaimer has been issued, 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. This will be the rate component. Inflation will not be added to transportation costs.

ii. Providers that have gone through a change of ownership (CHOW), as described in §723.E.2, will be reimbursed for transportation costs based upon the previous owner's specific allowable quarter hour transportation costs for the period of time between the effective date of the CHOW and the first succeeding base year in which the new owner could possibly file an allowable 12-month cost report. Thereafter, the new owner's data will be used to determine the provider's rate following the procedures specified in this Rule.

iii. Providers that have been issued an audit disclaimer, or have a non-filer status, as described in §723.E.3, will be reimbursed for transportation costs at a rate equal to the lowest allowable quarter hour transportation cost (excluding providers with no transportation costs) in the state as of the most recent audited and/or desk reviewed rate database.

iv. For rate periods between rebasing years, if a provider discontinues transportation services and reported no transportation costs on the most recently audited or desk reviewed cost report, no center specific transportation rate will be added to the center's total rate for the rate year.

7. Budgetary Constraint Rate Adjustment. Effective for the rate period July 1, 2011 to July 1, 2012, the allowable quarter hour rate components for direct care, care related, administrative and operating, property, and transportation shall be reduced by 10.8563 percent.

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 department 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 department may initiate a rate change without a request to do so. Changes to the rates may be temporary adjustments or base rate adjustments as described below.

a. Temporary Adjustments. 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.

9. Provider Specific Adjustment. When services required by these provisions are not made available to the participant by the provider, the department may adjust the prospective payment rate of that specific provider by an amount that is proportional to the cost of providing the service. This adjustment to the rate will be retroactive to the date that is determined by the department that the provider last provided the service and shall remain in effect until the department validates, and accepts in writing, an affidavit that the provider is then providing the service and will continue to provide that service.

C. Cost Settlement. The direct care cost component shall be subject to cost settlement. The direct care floor shall be equal to 70 percent of the median direct care rate component trended forward for direct care services (plus 70 percent of any direct care incentive added to the rate). The Medicaid Program will recover the difference between the direct care floor and the actual direct care amount expended. If a provider receives an audit disclaimer, the cost settlement for that year will be based on the difference between the direct care floor and the lowest direct care per diem of all centers in the most recent audited and/or desk reviewed database. If the lowest direct care per diem of all centers in the most recent audited and/or desk reviewed database is lower than 50 percent of the direct care rate paid for that year, 50 percent of the direct care rate paid will be used as the provider's direct care per diem for settlement purposes.

D. Support Coordination Services Reimbursement. Support coordination services previously provided by ADHC providers and included in the rate, including the interRAI Home Care assessment, the social assessment, the nursing assessment, the plan of care (POC) and home visits are no longer the responsibility of the ADHC provider. Support coordination services shall be provided as a separate service covered in the waiver programs. As a result of the change in responsibilities, the rate paid to ADHC providers was adjusted accordingly.

E. New Centers, Changes of Ownership of Existing Centers, and Existing Centers with Disclaimer or Non-Filer Status.

1. New centers are those entities whose beds have not previously been certified to participate, or otherwise have participated, in the Medicaid program. New centers will be reimbursed in accordance with this Rule and receiving the direct care, care related, administrative and operating, property rate components as determined in §723.B.1-6. These new centers will also receive the state-wide average transportation rate component, as calculated in §723.B.6.e.i.(a), effective the preceding July 1.

2. A change of ownership exists if the beds of the new owner have previously been certified to participate, or otherwise have participated, in the Medicaid program under the previous owner's provider agreement. Rates paid to centers that have undergone a change in ownership will be based upon the rate paid to the previous owner for all rate components. Thereafter, the new owner's data will be used to determine the center's rate following the procedures in this Rule.

3. Existing providers that have been issued an audit disclaimer, or are a provider who has failed to file a complete cost report in accordance with §711, will be reimbursed based upon the statewide allowable quarter hour median costs for the direct care, care related, administrative and operating, and property rate components as determined in §723.B.1-7. No inflation or median adjustment factor will be included in these components. The transportation component will be reimbursed as described in §723.B.6.e.iii.

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, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1120 (August 2021).

Chapter 9. Provider Requirements

Subchapter A. General Provisions

§901. Settings Requirements for Service Delivery

A. All home and community-based services (HCBS) delivered through a 1915(c) waiver must be provided in settings with the following qualities:

1. the setting is integrated in and supports full access of waiver participants to the greater community, including opportunities to:

a. seek employment and work in competitive integrated settings;

b. control personal resources;

c. engage in community life; and

d. receive services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services;

2. the setting is selected by the participant from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the participant's needs, preferences, and, for residential settings, resources available for room and board;

3. the setting ensures a participant's rights of privacy, dignity and respect, and freedom from coercion and restraint;

4. the setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact; and

5. the setting facilitates individual choice regarding services and supports, and who provides them.

B. In a provider-owned or controlled non-residential setting, in addition to the qualities listed in Subsection A above, the following additional conditions must be met:

1. participants shall have the freedom and support to control their own schedules and activities, and have access to food at any time to the same extent as participants not receiving Medicaid home and community-based waiver services;

2. participants shall be able to have visitors of their choosing at any time to the same extent as participants not receiving Medicaid home and community-based waiver services; and

3. the setting shall be physically accessible to the participant.

C. In a provider-owned or controlled residential setting, in addition to the qualities listed in Subsections A and B above, the following additional conditions must be met.

1. The unit or dwelling shall be a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant laws of the state, parish, city, or other designated entity. For settings in which landlord/tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord/tenant law.

2. Each participant shall have privacy in their sleeping or living unit.

a. Units shall have entrance doors lockable by the participant, with only appropriate staff having keys to doors.

b. Participants sharing units shall have a choice of roommates in that setting.

c. Participants shall have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

D. Providers shall work with the department to timely address and remediate any identified instances of non-compliance.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities, LR 43:1978 (October 2017), amended LR 45:1080 (August 2019).

§903. Electronic Visit Verification

A. An electronic visit verification (EVV) system must be used for time and attendance tracking and post-authorization for home and community-based services.

1. Home and community-based waiver providers identified by the department shall use:

a. the EVV system designated by the department, or

b. an alternate system that:

i. has successfully passed the data integration process to connect to the designated EVV system, and

ii. is approved by the department.

2. Reimbursement for services may be withheld or denied if a provider:

a. fails to use the EVV system, or

b. uses a system not in compliance with Medicaid's policies and procedures for EVV.

3. Requirements for proper use of the EVV system are outlined in the respective program's Medicaid provider manual.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities, LR 43:1979 (October 2017), amended LR 45:1081 (August 2019).

§904. Social Security Verification

A. Home and community-based waiver providers shall verify all currently employed and all new employees' Social Security numbers either by obtaining a copy of the employee's Social Security card or through a Social Security number verification service.

B. A copy of the employee's Social Security card or proof of verification shall be kept in the employee's record.

1. The department or its designee reserves the right to request verification of an employee's Social Security number at any time.

2. Should the provider be unable to provide proof of verification, payments associated with that employee's previously billed time may be recouped and/or future reimbursement withheld until proper verification is submitted.

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, Bureau of Health Services Financing and the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities, LR 45:1081 (August 2019).

§905. Critical Incident Reporting

A. Support coordination and direct service provider types are responsible for documenting the occurrence of incidents or accidents that affect the health and welfare of the participant, and for completing an incident report.

B. The incident report shall be submitted to the department, or its designee, with the specified requirements and within specified time lines.

C. Specific requirements and timelines are outlined in each program office's *Critical Incident Reporting Policy and Procedures* document.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities, LR 43:1979 (October 2017).

Chapter 11. Fiscal Employer Agent Standards for Participation in Home and Community-Based Services Waiver Programs

Subchapter A. General Provisions

§1101. Introduction

A. The Department of Health (LDH) establishes these minimum standards for participation as a fiscal employer agent (F/EA). These standards provide the core requirements for financial management services provided under home and community-based services waiver programs administered by the Office of Aging and Adult Services (OAAS), the Office for Citizens with Developmental Disabilities (OCDD), and the Bureau of Health Services Financing (BHSF).

B. LDH is responsible for setting the standards for F/EAs, monitoring the provisions of this Rule, and applying administrative sanctions for failures to meet the minimum standards for participation in serving employers/participants of the OAAS and OCDD-administered waiver programs.

C. The F/EA provides financial management services for participants who are eligible for self-directed waiver services. Under this service model, the F/EA assists individuals with management of fiscal employment and/or budget responsibilities and will provide the employer/participant with current utilization information to ensure self-directed services are not exceeded beyond the prior authorization cap; processes employer-related payroll and necessary taxes on behalf of self-direction participants. The F/EA also verifies qualifications (e.g., background checks, exclusion checks, etc.) for employees hired by the employers.

D. Medicaid-enrolled F/EAs providing financial management services at the time of OCDD and OAAS-administered waiver programs shall be required to meet the requirements of this Chapter.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1559 (September 2023).

§1103. Certification Requirements

A. All F/EAs that provide financial management services must be certified through completion of a readiness review by LDH. It shall be unlawful to operate as an F/EA without being certified by LDH.

B. In order to provide financial management services, the F/EA must:

1. be certified through completion of a readiness review and meet the standards for participation requirements as set forth in this Rule;

2. sign a performance agreement with LDH;

3. enroll as an F/EA with the Louisiana Medicaid program to provide services for OCDD and OAAS-administered home and community-based services; and

4. comply with all policies and procedures set forth by LDH.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1560 (September 2023).

§1105. Certification Issuance

A. A certification shall:

1. be issued only to the F/EA named in the certification application;

2. be valid only for the F/EA to which it is issued after all applicable requirements are met;

3. enable the F/EA to provide financial management services for OCDD and OAAS-administered home and community-based services waivers statewide;

4. be valid indefinitely, unless revoked, suspended, modified, or terminated; and

5. be issued by LDH.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1560 (September 2023).

§1107. Certification Refusal or Revocation and Fair Hearing

A. A certification may be revoked or refused if applicable certification requirements, as determined by LDH, have not been met. Certification decisions are subject to appeal and fair hearing, in accordance with R.S. 46:107(A)(3).

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1560 (September 2023).

§1109. Certification Review

A. Compliance with certification requirements is determined by LDH through its F/EA monitoring processes. Monitors must be given access to data upon request by LDH to ensure the F/EA continues to meet certification requirements.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1560 (September 2023).

Subchapter B. Administration and Organization

§1115. Governing Body

A. The F/EA shall have an identifiable governing body with responsibility for and authority over its policies and activities.

B. The F/EA shall have documents identifying all members of the governing body, their addresses, their terms of membership, and officers of the governing body.

C. The governing body of the F/EA shall:

1. ensure continual compliance and conformity with all relevant federal, state, local, and municipal laws and regulations;

2. ensure the F/EA is adequately funded and fiscally sound;

3. review and approve the F/EA's annual budget; and

4. designate a person to act as administrator and delegate sufficient authority to this person to manage the F/EA.

D. The F/EA shall maintain an administrative file that includes:

1. documents identifying the governing body;

2. a list of members and officers of the governing body, along with their addresses and terms of membership;

3. minutes of formal meetings and by-laws of the governing body, if applicable;

4. documentation of the F/EA's authority to operate under state law;

5. an organizational chart of the F/EA which clearly delineates the line of authority;

6. all leases, contracts and purchases-of-service agreements to which the F/EA is a party;

7. insurance policies;

8. annual budgets and, if performed, audit reports;

9. the F/EA's policies and procedures; and

10. documentation of any corrective action taken as a result of external or internal reviews.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1560 (September 2023).

§1117. Business Location and Operations

A. The F/EA shall have a business location which shall not be in an occupied personal residence. The F/EA must maintain the following at the business location:

1. staff to perform administrative functions;

2. direct service worker/employee personnel records; and

3. participant service records.

B. The F/EA shall have the following for the business location:

1. a published nationwide toll-free telephone number that is available during business hours and capable of receiving messages 24 hours a day, seven days a week, including holidays;

2. a published business telephone number answered by staff during business hours;

3. a business fax number that is operational 24 hours a day, seven days a week, including holidays;

4. internet access;

5. a designated e-mail mailbox to receive inquiries from Medicaid beneficiaries and LDH; and

6. business hours shall be at least 8 a.m. to 5 p.m. CT, Monday through Friday, excluding official state holidays.

C. Records and other confidential information shall be secure and protected from unauthorized access.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1561 (September 2023).

§1119. Financial Management

A. The F/EA must establish a system of financial management and staffing to assure maintenance of complete and accurate accounts, books, and records in keeping with generally accepted accounting principles.

B. The F/EA must not permit public funds to be paid, or committed to be paid, to any person who is a member of the governing board or administrative personnel who may have any direct or indirect financial interest, or in which any of these persons serve as an officer or employee, unless the services or goods involved are provided at a competitive cost or under terms favorable to the F/EA.

1. The F/EA shall have a written disclosure of any financial transaction with the F/EA in which a member of the governing board, administrative personnel, or his/her immediate family is involved.

C. To ensure the F/EA's ability to pay direct service workers for waiver services delivered, the F/EA shall have and maintain documented evidence of an available line of credit of at least $1,000,000 or a cash reserve sufficient to cover the cost of two payroll cycles.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1561 (September 2023).

§1121. Policy and Procedures

A. The F/EA shall have written policies and procedures approved by the owner or governing body which must be implemented and followed that address at a minimum the following:

1. confidentiality and confidentiality agreements;

2. security of files;

3. publicity and marketing, including the prohibition of illegal or coercive inducement, solicitation, and kickbacks;

4. personnel;

5. grievance procedures;

6. emergency preparedness;

7. procedures for reporting suspected abuse, neglect, exploitation, and extortion;

8. procedures for reporting suspected fraud;

9. documentation; and

10. enrollment/disenrollment procedures.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1561 (September 2023).

§1123. Organizational Communication

A. The F/EA must establish procedures to assure adequate communication among staff to provide continuity of services to the participant and to facilitate feedback from staff, participants, families, and when appropriate, the community.

B. The F/EA must have brochures and make them available to LDH or its designee. The brochures must include the following information:

1. a toll-free number and email address to direct customer service questions or to receive assistance;

2. information on how to make a complaint if they are dissatisfied with F/EA services; and

3. a description of the F/EA, services provided, current mailing and physical addresses, website information, and the F/EA's toll-free number.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1561 (September 2023).

Subchapter C. Provider Responsibilities

§1129. General Provisions

A. Any entity wishing to provide F/EA services shall meet all of the standards for participation contained in this Rule, unless otherwise specifically noted within these provisions.

B. The F/EA shall also abide by and adhere to any federal and state law, Rule, policy, procedure, performance agreement, or other state or federal requirements pertaining to the provision of F/EA services.

C. Failure to comply with the requirements of these standards for participation may result in the following actions including, but not limited to:

1. recoupment of funds;

2. sanctions for violations/non-performance as outlined in the performance agreement;

3. citation of deficient practice and plan of correction submission;

4. removal from the F/EA freedom of choice list; or

5. decertification as an F/EA and termination of the F/EA's Medicaid provider enrollment.

D. The F/EA shall make any required information or records, and any information reasonably related to assessment of compliance with these requirements, available to LDH.

E. The F/EA shall, upon request by LDH, make available the legal ownership documents of the F/EA.

F. The F/EA must comply with all of LDH's systems/software requirements, including the following:

1. The F/EA is required to transmit all non-proprietary data which is relevant for analytical purposes to LDH on a regular schedule in XML format.

a. Final determination of relevant data will be made by LDH based on collaboration between all parties;

b. The schedule for transmission of the data will be established by LDH and dependent on the needs of LDH related to the data being transmitted;

c. XML files for this purpose will be transmitted via secure file transfer protocol (SFTP) to LDH; and

d. Any other data or method of transmission used for this purpose must be approved via written agreement by all parties.

2. The F/EA is responsible for procuring and maintaining hardware and software resources which are sufficient for it to successfully perform the services detailed in this Rule.

3. The F/EA shall adhere to state and federal regulations and guidelines as well as industry standards and best practices for systems or functions required to support the requirements of this Rule.

4. Unless explicitly stated to the contrary, the F/EA is responsible for all expenses required to obtain access to LDH systems or resources which are relevant to successful completion of the requirements of this agreement. The F/EA is also responsible for expenses required for LDH to obtain access to the F/EA's systems or resources which are relevant to the successful completion of the requirements of this agreement. Such expenses are inclusive of hardware, software, network infrastructure, and any licensing costs.

5. The F/EA, for all confidential or protected health information, must be encrypted to federal information processing standards (FIPS) 140-2 standards when at rest or in transit.

6. The F/EA shall ensure appropriate protections of shared personally identifiable information (PII), in accordance with 45 CFR §155.260.

7. The F/EA shall ensure that its system is operated in compliance with the Centers for Medicare and Medicaid Services' (CMS) latest version of the minimum acceptable risk standards for exchanges (MARS-E) document suite.

8. Multi-factor authentication is a CMS requirement for all remote users, privileged accounts, and non-privileged accounts. In this context, remote user refers to staff accessing the network from offsite, normally with a client virtual private network (VPN) with the ability to access Medicaid and PII data.

9. A site-to-site tunnel is an extension of LDH's network. If the agent utilizes a VPN site-to-site tunnel and also has remote users who access CMS data, the agent is responsible for providing and enforcing multi-factor authentication.

10. The F/EA owned resources must be compliant with industry standard physical and procedural safeguards (NIST SP 800-114, NIST SP 800-66, NIST 800-53A, ISO 17788, etc.) for confidential information (i.e., health information technology for economic and clinical health (HITECH), health insurance portability and accountability act (HIPAA) part 164).

11. Any F/EA use of flash drives or external hard drives for storage of LDH data must first receive written approval from LDH and upon such approval shall adhere to FIPS 140-2 hardware level encryption standards.

12. All F/EA utilized computers and devices must:

a. be protected by industry standard virus protection software that is automatically updated on a regular schedule;

b. have installed all security patches which are relevant to the applicable operating system and any other system software; and

c. have encryption protection enabled at the operating system level.

G. F/EAs shall, at a minimum:

1. demonstrate administrative capacity and the financial resources to provide all core elements of financial management services and ensure effective service delivery in accordance with state and federal requirements;

2. have appropriate F/EA staff attend trainings, as mandated by LDH;

3. document and maintain records in accordance with federal and state regulations governing confidentiality and program requirements; and

4. assure that the F/EA will not provide both financial management services and support coordination or personal care services in Louisiana.

H. Abuse and Neglect. Fiscal employer agencies shall establish policies and procedures relative to the reporting of abuse, neglect, exploitation, and extortion of participants, pursuant to the provisions of R.S. 15:1504-1505, R.S. 40:2009.20 and any subsequently enacted laws. The F/EA shall ensure that staff complies with these regulations.

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, Bureau of Health Services Financing, the Office of Aging

and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1561 (September 2023).

§1131. Fiscal Employer Agent Requirements

A. The F/EA must comply with requirements for financial management services in self-direction including, but not limited to:

1. verifying qualifications of employers and support workers;

2. processing payroll, including applying applicable withholds and filing/paying all required state and federal income taxes;

3. disbursing payment to direct support workers;

4. setting up accounting records to track expenses;

5. setting up procedures for processing payroll and non-labor items;

6. maintaining all records related to the direct support worker's payroll, taxes, and benefits;

7. producing and sending required reports to LDH;

8. providing support to self-direction employers;

9. billing the LDH fiscal intermediary for Medicaid service claims and making refunds to LDH as appropriate;

10. resolving all billing discrepancies timely;

11. utilizing an LDH approved payroll calendar that addresses tax obligations; and

12. utilizing a system capable of capturing, recording, and tracking service, payroll, and tax information.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1562 (September 2023).

§1133. Transfers and Discharges

A. Participant has the right to choose among the F/EAs certified by LDH and enrolled in the Louisiana Medicaid Program. This includes the right to transition to another F/EA.

B. Upon notice by the participant or his/her authorized representative that the participant has selected another F/EA or the participant has decided to discontinue participation in the self-direction program, the F/EA is responsible for planning and facilitating the participant's transfer or discharge.

C. The F/EA shall facilitate transfer to another F/EA when it ceases to operate or its Medicaid enrollment is terminated.

D. The transfer or transition responsibilities of the F/EA shall include:

1. working with the F/EA selected by the participant to transition by ensuring the following documents/information are submitted to the new provider: participant/employer wages, federal employment identification number (FEIN), and state unemployment tax act (SUTA) account information including username and password;

2. ensuring that there is only one F/EA for a given employer at any time;

3. adhering to specific processes and procedures when transitioning a participant to a new F/EA in accordance with all federal, state, and local laws; and

4. documenting the activities that are required to transition the participant to the receiving F/EA.

E. The F/EA shall not coerce or attempt to influence the participant's choice of F/EA. Failure to cooperate with the participant's decision to transfer to another F/EA will result in adverse action by LDH.

F. If the F/EA ceases to operate, the F/EA must give LDH at least 60 days written notice of its intent to close.

1. The transition plan for all participants served by the F/EA shall be completed within 10 working days of the notice to LDH of the F/EA's intent to close to minimize disruption of payroll services provided for employers.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1563 (September 2023).

§1135. Staffing Requirements

A. F/EAs must maintain sufficient staff to comply with LDH regulations and policies for the self-direction program. The F/EA shall:

1. employ at least one staff member with a bachelor's degree in accounting and five years of applicable experience, or a master's degree in accounting and two years of applicable experience, or a master's degree in accounting and two years of applicable experience;

2. must have on staff a database administer and sufficient programmers to ensure that systems comply with program requirements and are flexible enough to accommodate changes to those requirements; and

3. must designate a project director who will have day-to-day authority to manage the overall operations.

a. The project director will be available to LDH by telephone, e-mail, and video conferencing during regular business hours.

B. In the event LDH determines that the F/EA staffing levels do not conform to the above requirements, LDH shall advise the F/EA in writing and the F/EA shall submit a corrective action plan within five business days. This plan shall describe how the deficiency(ies) will be remedied and is subject to LDH approval.

C. The F/EA shall ensure all staff supporting the self-direction program are not excluded from participating in the Medicaid program by confirming each staff's name and social security number are not included on the Louisiana adverse actions list and Office of Inspector General (OIG) exclusions list.

D. Each F/EA shall ensure that staff is available at times which are convenient and responsive to the needs of participants and their families.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1563 (September 2023).

§1137. Employer Rights

A. Each F/EA's written policies and procedures, at a minimum, shall ensure the employer's right to:

1. confidentiality;

2. privacy;

3. impartial access to F/EA services regardless of race, religion, sex, ethnicity, or disability;

4. access to the interpretive services, translated material and similar accommodations as appropriate;

5. access to his/her records upon the participant's written consent for release of information;

6. an explanation of the nature of services to be received;

7. file a complaint or grievance without retribution, retaliation, or discharge;

8. have access to information related to tracking their budget and service balance; and

9. discontinue services with their F/EA and choose another F/EA.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1563 (September 2023).

§1139. Grievances

A. The F/EA shall establish and follow a written grievance procedure to be used to process complaints by employers, their family member(s), or a legal representative that is designed to allow employers to make complaints without fear of retaliation. The written grievance procedure shall be provided to the employer.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1564 (September 2023).

§1141. Electronic Visit Verification (EVV) Requirements

A. The F/EA must have an electronic visit verification (EVV) system in place that complies with the 21st Century Cures Act. The F/EA's EVV system must verify the type of service provided, the individual receiving the service, the individual providing the service, date of service, location of the service (geolocation), and time the service begins and ends.

B. Services may be verified via smart phone, telephony (landline from participant's home), or a fixed visit verification device in the participant's home. Other methods of verification may be submitted to LDH for consideration and approval.

C. The F/EA is responsible for ensuring the system used meets the requirements specified in the LDH attestation for third party EVV systems.

1. The system shall have the capability to interface with LDH's EVV system.

2. The F/EA's system and its interface shall pass testing required by the data integration process prior to go-live.

3. The F/EA will be required to collect electronic check in/check out information including geolocation data in accordance with state requirements.

D. The F/EA must provide a user-friendly EVV system, including an alternate method of collecting time should the EVV system becomes unavailable.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1564 (September 2023).

§1143. Employer Records

A. The F/EA shall store employer/employee records securely and protected in accordance with HIPAA requirements at the F/EA's place of business.

B. F/EAs shall maintain employer and employee records for at least six years or longer when required by state or federal law.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1564 (September 2023).

§1145. Emergency Preparedness

A. The F/EA, regardless of the architecture of its systems, shall develop and be continually ready to invoke an all hazards plan to protect the availability, integrity, and security of data during unexpected failures or disasters (either natural or man-made) to continue essential

application or system functions during or immediately following failures or disasters.

B. The all hazards plan shall include a disaster recovery plan (DRP) and a business continuity plan (BCP). A DRP is designed to recover systems, networks, workstations, applications, etc., in the event of a disaster. A BCP shall focus on restoring the operational function of the organization in the event of a disaster and includes items related to information technology (IT), as well as operational items such as employee notification processes and the procurement of office supplies needed to do business in the emergency mode operation environment. The practice of including both the DRP and the BCP in the all hazards planning process is a best practice. At a minimum, the all hazards plan shall address the following scenarios:

1. the central computer installation and resident software are destroyed or damaged;

2. the system interruption or failure resulting from network, operating hardware, software, or operations errors that compromise the integrity of transaction that are active in a live system at the time of the outage; and

3. system interruption or failure resulting from network, operating hardware, software or operations errors that compromise the integrity of data maintained in a live or archival system.

C. The all hazards plan shall specify projected recovery times and data loss for mission-critical systems in the event of a declared disaster. The following minimum criteria are required:

1. system restoration within 24 hours;

2. two physical locations for maintaining data; and

3. backups of all system data every 24 hours.

D. The F/EA shall annually test its plan through simulated disasters and lower level failures in order to demonstrate to LDH that it can restore system functions. In the event the F/EA fails to demonstrate through these tests that it can restore system functions, the F/EA shall be required to submit a corrective action plan to LDH describing how the failure shall be resolved within 10 business days of the conclusion of the test.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1564 (September 2023).

§1147. Fiscal Employer Agent Monitoring

A. F/EAs shall be monitored on an on-going basis as outlined in the performance agreement.

B. F/EAs shall offer full cooperation with LDH during the monitoring process.

C. Responsibilities of the F/EA in the monitoring process include, but are not limited to, providing policy and procedure manuals, employer/employee records, and other documentation as requested.

D. F/EAs shall cooperate with any audit requests from state or federal agencies.

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, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1564 (September 2023).

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 waived service under the provisions of Title XIX of the Social Security Act and is administrated by the Department of Health (LDH).

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.

C. Any provider of services under the ADHC waiver shall abide by and adhere to any federal or state laws, rules, policy, procedures, or manuals issued by the department. Failure to do so may result in sanctions.

D. Each individual who requests ADHC waiver services has the option to designate a responsible representative. For purposes of these provisions, a responsible representative shall be defined as the person designated by the individual to act on his/her behalf in the process of accessing and/or maintaining ADHC waiver services.

1. The appropriate form authorized by the Office of Aging and Adult Services (OAAS) shall be used to designate a responsible representative.

a. The written designation of a responsible representative does not take away the right of the individual to continue to transact business on his/her own behalf nor does it give the representative any legal authority other than as specified in the designation form.

b. The written designation is valid until revoked by the individual granting the designation.

i. To revoke the written designation, the revocation must be submitted in writing to OAAS or its designee.

2. The functions of a responsible representative are to:

a. assist and represent the individual in the assessment, care plan development and service delivery processes; and

b. aid the participant in obtaining all of the necessary documentation for these processes.

3. No individual, unless granted an exception by OAAS, may concurrently serve as a responsible representative for more than two participants in OAAS-operated Medicaid home and community-based service programs including:

a. the Program of All-Inclusive Care for the Elderly (PACE);

b. long-term personal care services (LT-PCS);

c. the Community Choices Waiver; and

d. the Adult Day Health Care Waiver.

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), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2161 (October 2008), repromulgated LR 34:2565 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2494 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2162 (December 2018), LR 50:382 (March 2024).

§2103. Program Description

A. An Adult Day Health Care Waiver Program expands the array of services available to individuals with functional impairments, and helps to bridge the gap between independence and institutional care by allowing them to remain in their own homes and communities. This program provides direct care for individuals who have physical, mental or functional impairments. ADHC waiver participants must attend a minimum of 36 days per calendar quarter, absent extenuating circumstances. Exceptions for extenuating circumstances must be approved by the assigned support coordinator based upon guidance provided by OAAS.

B. The target population for the ADHC Waiver Program includes individuals who:

1. are 65 years old or older; or

2. are 22 to 64 years old and with a physical disability; and

3. meet nursing facility level of care requirements.

C. The long-range goal for all adult day health care participants is the delay or prevention of long-term care facility placement. The more immediate goals of the Adult Day Health Care Waiver are to:

1. promote the individual's maximum level of independence;

2. maintain the individual's present level of functioning as long as possible, preventing or delaying further deterioration;

3. restore and rehabilitate the individual to the highest possible level of functioning as may be practicable under the circumstances;

4. provide support and education for families and other caregivers;

5. foster socialization and peer interaction; and

6. serve as an integral part of the community services network and the long-term care continuum of 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 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), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2161 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2624 (September 2011), LR 39:2495 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:382 (March 2024).

§2105. Request for Services Registry [Formerly §2107]

A. The Department of Health is responsible for the Request for Services Registry, hereafter referred to as "the registry", for the ADHC 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 LDH.

B. Individuals who desire their name to be placed on the ADHC waiver registry shall be screened to determine whether they:

1. meet nursing facility level of care; and

2. are members of the target population as identified in the federally-approved waiver document.

C. Only individuals who pass the screening in §2105.B shall be added to the registry.

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 34:2161 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2495 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2163 (December 2018).

§2107. 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 to individuals on the registry according to priority groups. The following groups shall have priority for ADHC waiver opportunities in the order listed:

1. individuals with substantiated cases of abuse or neglect referred by protective services who, without ADHC waiver services, would require institutional placement to prevent further abuse and neglect;

2. individuals who have been discharged after a hospitalization within the past 30 calendar days that involved a stay of at least one night;

3. individuals admitted to, or residing in, a nursing facility who have Medicaid as the sole payer source for the nursing facility stay; and

4. all other eligible individuals on the Request for Services Registry (RFSR), by date of first request for services.

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 Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2624 (September 2011), LR 39:2495 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2163 (December 2018).

Chapter 23. Services

§2301. Covered Services

A. The following services are available to participants in the ADHC Waiver. All services must be provided in accordance with the approved plan of care (POC). No services shall be provided until the POC has been approved.

1. Adult Day Health Care. Services furnished as specified in the POC at a licensed ADHC center, in a non-institutional, community-based setting encompassing both health/medical and social services needed to ensure the optimal functioning of the participant. Services are furnished on a regularly scheduled basis, not to exceed 10 hours a day, 50 hours a week. ADHC services include those core service requirements identified in the ADHC licensing standards (LAC 48:I.4243) in addition to:

a. medical care management; and

b. transportation to and from medical and social activities (if the participant is accompanied by the ADHC center staff).

2. Support Coordination. These services assist participants in gaining access to necessary waiver and other state plan services, as well as needed medical, social, educational, housing, and other services, regardless of the funding source for these services. Support coordination agencies shall be required to perform the following core elements of support coordination services:

a. intake;

b. assessment and reassessment;

c. plan of care development and revision;

d. follow-up/monitoring;

e. critical incident management; and

f. transition/discharge and closure.

3. Transition Intensive Support Coordination. These services will assist participants currently residing in nursing facilities in gaining access to needed waiver and other state plan services, as well as needed medical, social, housing, educational and other services regardless of the funding source for these services. Support coordinators shall initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the participants approved POC.

a. This service is paid up to six months prior to transitioning from the nursing facility when adequate pre-transition supports and activities are provided and documented.

b. The scope of transition intensive support coordination shall not overlap with the scope of support coordination.

c. Support coordinators may assist participants to transition for up to six months while the participants still reside in the facility.

4. Transition Services. These services are time limited, non-recurring set-up expenses available for individuals who have been offered and approved for an ADHC waiver opportunity and are transitioning from a nursing facility to a living arrangement in a private residence where the individual is directly responsible for his/her own expenses.

a. Allowable expenses are those necessary to enable the individual to establish a basic household (excluding expenses for room and board) including, but not limited to:

i. security deposits that are required to obtain a lease on an apartment or house;

ii. specific set up fees or deposits;

iii. activities to assess need, arrange for and procure needed resources;

iv. essential furnishings to establish basic living arrangements; and

v. health, safety, and welfare assurances.

b. These services must be prior approved in the participant's plan of care.

c. These services do not include monthly rental charges, mortgage expenses, food, recurring monthly utilities charges, household appliances, and/or items intended for purely diversional/recreational purposes.

d. These services may not be used to pay for furnishings or set-up living arrangements that are owned or leased by a waiver provider.

e. Support coordinators shall exhaust all other resources to obtain these items prior to utilizing the waiver.

f. Funds are available for specific items up to the lifetime maximum amount identified in the federally-approved waiver document.

5. Assistive Technology. These services include the following:

a. an item, piece of equipment, or product system, acquired commercially, that is used to increase, maintain, or improve functional capabilities of participants; and

b. the assistance provided to the participant in the acquisition, set up, and use of an assistive technology device:

i. evaluating to determine if an assistive technology device is appropriate for the participant;

ii. purchasing the most appropriate assistive technology device for the participant; and

iii. costs associated with the delivery, set up, and training.

6. ADHC Health Status Monitoring (HSM). This service monitors the status of participants that are unable to attend the ADHC on their scheduled day as outlined in the approved plan of care.

a. The ADHC provider may utilize this service and contact the participant via telephone to check in on the participant and provide follow-up on any need identified during the telephone contact.

7. Home Delivered Meals (HDMs). These services assist in meeting the nutritional needs of a participant in support of the maintenance of self-sufficiency and enhancing the quality of life.

a. Up to two nutritionally balanced meals per day may be delivered to the home of an eligible participant who is unable to prepare their own meals, and/or has no responsible caregiver in the home on days that the participant is not scheduled to attend the ADHC center.

b. Each meal shall provide a minimum of one-third of the current recommended dietary allowance (RDA) for the participant as adopted by the United States Department of Agriculture. The provision of HDMs does not provide a full nutritional regimen.

8. Activity and Sensor Monitoring (ASM). This is a computerized system that monitors the participant's in-home movement and activity for health, welfare, and safety purposes.

a. The provider agency is responsible for monitoring electronically-generated information, for responding as needed, and for equipment maintenance.

b. ASM must meet applicable manufacturing, design and installation standards.

c. ASM must be prior authorized and no experimental items shall be authorized.

9. Personal Emergency Response System (PERS). This is an electronic device which enables participants to secure help in an emergency. PERS is appropriate for participants who are cognitively and/or physically able to operate the system and who are alone for significant periods of time.

a. PERS must meet applicable manufacturing, design, and installation standards.

b. PERS must be prior authorized and no experimental items shall be authorized.

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), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2495 (September 2013), LR 40:791 (April 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2163 (December 2018), LR 49:486 (March 2023), LR 50:382 (March 2024).

§2303. Individualized Service Plan

A. All participants shall have an ADHC individualized service plan (ISP) written in accordance with ADHC licensing standards (LAC 48:I.4281).

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), amended by the Department of

Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2567 (December 2008), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2164 (December 2018).

§2305. Plan of Care

A. The applicant and support coordinator have the flexibility to construct a plan of care (POC) that serves the participant's health, safety and welfare needs. The service package provided under the POC shall include services covered under the Adult Day Health Care Waiver, Medicaid State Plan services, and any other services, regardless of the funding source.

1. All services approved pursuant to the POC shall be medically necessary and provided in a cost-effective manner.

2. The POC shall be developed using a person-centered process coordinated by the support coordinator.

B. Reimbursement shall not be made for adult day health care waiver services provided prior to the department's, or its designee's, approval of the POC.

C. The POC shall contain the:

1. types and number of services (including waiver and all other services) necessary to reasonably assure health and welfare and to maintain the individual in the community;

2. individual cost of each waiver service; and

3. total cost of waiver services covered by the POC.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2496 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2164 (December 2018).

Chapter 25. Admission and Discharge Criteria

§2501. Admission Criteria

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

1. meets the target population criteria as specified in the approved waiver document;

2. initial and continued Medicaid eligibility;

3. initial and continued eligibility for nursing facility level of care;

4. justification, as documented in the approved POC, that the ADHC waiver services are appropriate, cost-effective and represent the least restrictive environment for the individual; and

5. reasonable assurance that the health, safety and welfare of the individual can be maintained in the community with the provision of ADHC waiver services.

B. Failure of the individual to cooperate in the eligibility determination process, POC development, or to meet any of the criteria above shall result in denial of admission to the ADHC waiver.

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), amended by the Department Of Hospitals, Office of Aging and Adult Services, LR 34:2163 (October 2008), repromulgated LR 34:2568 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2496 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2164 (December 2018).

§2503. Admission Denial or Discharge Criteria

A. Admission shall be denied or the participant shall be discharged from the ADHC Waiver Program if any of the following conditions are determined.

1. The individual does not meet the target population criteria as specified in the federally approved waiver document.

2. The individual does not meet the criteria for Medicaid eligibility.

3. The individual does not meet the criteria for nursing facility level of care.

4. The individual resides in another state or the participant has a change of residence to another state.

5. Continuity of services is interrupted as a result of the participant not receiving and/or refusing ADHC waiver services (exclusive of support coordination services) for a period of 30 consecutive days.

a. Exceptions may be granted by OAAS to delay discharge if interruption is due to an acute care hospital, rehabilitation hospital, or nursing facility admission.

6. The health, safety and welfare of the individual cannot be assured through the provision of ADHC waiver services.

7. The individual/participant fails to cooperate in the eligibility determination process, POC development, or in the performance of the POC.

8. It is not cost effective or appropriate to serve the individual in the ADHC Waiver.

9. The participant fails to attend the ADHC center for a minimum of 36 days per calendar quarter.

10. The participant fails to maintain a safe and legal home environment.

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 Aging and Adult Services, LR 34:2163 (October 2008), repromulgated LR 34:2568 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2496 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2165 (December 2018).

Chapter 27. Provider Responsibilities

§2701. General Provisions

A. Each ADHC center shall:

1. be licensed by the Department of Health, Health Standards Section, in accordance with LAC 48:I.Chapter 42;

2. enroll as an ADHC Medicaid provider;

3. enter into a provider agreement with the department to provide services; and

4. agree to comply with the provisions of this Rule.

B. The provider shall not request payment unless the participant for whom payment is requested is receiving services in accordance with the ADHC Waiver program provisions and the services have been prior authorized and delivered.

C. Adult day health care waiver providers shall not refuse to serve any participant who chooses their agency unless there is documentation to support an inability to meet the participant's health, safety and welfare needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services.

1. OAAS, or its designee, must be immediately notified of the circumstances surrounding a refusal by a provider to render services.

2. This requirement can only be waived by OAAS or its designee.

D. Providers must maintain adequate documentation to support service delivery and compliance with the approved POC and will provide said documentation at the request of the department, or its designee.

E. Adult day health care providers shall not interfere with the eligibility, assessment, care plan development or care plan monitoring processes with use of methods including, but not limited to:

1. harassment;

2. intimidation; or

3. threats against program participants, members of the participant's informal support network, LDH staff, or support coordination staff.

F. Adult day health care providers shall have the capacity and resources to provide all aspects of the services they are enrolled to provide in the specified licensed service area.

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), amended by the Department of Health and Hospitals, Office for Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2568 (December 2008),), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2497 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2165 (December 2018).

§2703. Reporting Requirements

A. Support coordinators and direct service providers, including ADHC providers, are obligated to immediately report any changes to the department that could affect the waiver participant's eligibility including, but not limited to, those changes cited in the denial or discharge criteria listed in §2503.

B. Support coordinators and direct service providers, including ADHC providers, are responsible for documenting the occurrence of incidents or accidents that affect the health, safety and welfare of the participant and completing an incident report. The incident report shall be submitted to the department or its designee with the specified requirements within specified time lines.

C. Support coordinators shall provide the participant's approved POC to the providers listed on the POC in a timely manner.

D. Adult day health care providers shall provide the participant's approved individualized service plan to the support coordinator in a timely manner.

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 of Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2568 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2497 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2165 (December 2018), LR 50:383 (March 2024).

Chapter 29. Reimbursement

§2901. Reimbursement and Rate Requirements

A. Adult day health care services shall be reimbursed according to LAC 50:XXI.709.

B. The following services shall be reimbursed at the authorized rate or approved amount of the installation, device/equipment, and when the service has been prior approved by the plan of care:

1. home delivered meals (not to exceed the maximum limit set by OAAS);

2. activity and sensor monitoring;

3. transition services (not to exceed the maximum lifetime limit set by OAAS);

4. personal emergency response system; and

5. assistive technology.

C. ADHC health status monitoring services shall be reimbursed as a per diem rate.

D. The following services shall be reimbursed at an established monthly rate:

1. support coordination;

2. transition intensive support coordination; and

3. monthly monitoring/maintenance for PERS and/or ASM services.

E. Reimbursement shall not be made for ADHC Waiver services provided prior to the department's approval of the POC and release of prior authorization for the services.

F. The state has the authority to set and change provider rates and/or provide lump sum payments to providers based upon funds allocated by the legislature.

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, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 49:683 (April 2023), amended LR 50:383 (March 2024).

§2903. Adult Day Health Care (ADHC) Direct Support Worker Wages, Other Benefits, and Workforce Retention Bonus Payments [Formerly LAC 50:XXI.2901]

A. Establishment of ADHC Direct Support Worker Wage Floor and Other Benefits

1. ADHC providers that were providing ADHC services on or after October 1, 2021 and employing ADHC direct support workers will receive a rate increase. The ADHC reimbursement rates shall be rebased resulting in an average increase of $4.31 per hour (rates differ based on facility specific transportation rate).

2. For direct support workers employed at the ADHC centers on or after October 1, 2021, 70 percent of the ADHC provider rate increases shall be passed directly to the ADHC direct support workers in the form of a minimum wage floor of $9 per hour and in other wage and non-wage benefits.

3. All ADHC providers affected by this rate increase shall be subject to passing 70 percent of their rate increases directly to the ADHC direct support worker in various forms. These forms include a minimum wage floor of $9 per hour and wage and non-wage benefits. This wage floor and wage and non-wage benefits are effective for all affected ADHC direct support workers of any working status, whether full-time or part-time.

4. The ADHC provider rate increases, wage floor, and/or wage and non-wage benefits will end March 31, 2025 or when the state's funding authorized under section 9817 of the American Rescue Plan Act of 2021 (Pub. L. No. 117-002) is exhausted.

5. The Department of Health (LDH) reserves the right to adjust the ADHC direct support worker wage floor and/or wage and non-wage benefits as needed through appropriate rulemaking promulgation consistent with the Administrative Procedure Act.

B. Establishment of Direct Support Worker Workforce Bonus Payments

1. ADHC providers who provided services from April 1, 2021 to October 31, 2022 shall receive bonus payments of $300 per month for each ADHC direct support worker that worked with participants for those months.

2. The ADHC direct support worker who provided services from April 1, 2021 to October 31, 2022 to participants must receive at least $250 of this $300 monthly bonus payment paid to the provider. This bonus payment is effective for all affected ADHC direct support workers of any working status, whether full-time or part-time.

C. Audit Procedures for ADHC Direct Support Worker Wage Floor, Other Benefits, and Workforce Bonus Payments

1. The wage enhancements, wage and non-wage benefits and bonus payments reimbursed to ADHC providers shall be subject to audit by LDH.

2. ADHC providers shall provide to LDH or its representative all requested documentation to verify that they are in compliance with the ADHC direct support worker wage floor, wage and non-wage benefits and/or bonus payments.

3. This documentation may include, but is not limited to, payroll records, wage and salary sheets, check stubs, copies of unemployment insurance files, etc.

4. ADHC providers shall produce the requested documentation upon request and within the timeframe provided by LDH.

5. Non-compliance or failure to demonstrate that the wage enhancement, wage and non-wage benefits and bonus payments were paid directly to ADHC direct support workers may result in the following:

a. sanctions; or

b. disenrollment from the Medicaid Program.

D. Sanctions for ADHC Direct Support Worker Wage Floor, Other Benefits and Workforce Bonus Payments

1. The ADHC provider will be subject to sanctions or penalties for failure to comply with this Rule or with requests issued by LDH pursuant to this Rule. The severity of such action will depend on the following factors:

a. failure to pass 70 percent of the ADHC provider rate increases directly to the ADHC direct support workers

in the form of a floor minimum of $9 per hour and in other wage and non-wage benefits and/or the $250 monthly bonus payments;

b. the number of employees identified that the ADHC provider has not passed 70 percent of the ADHC provider rate increases directly to the ADHC direct support workers in the form of a floor minimum of $9 per hour and in other wage and non-wage benefits and/or the $250 monthly bonus payments;

c. the persistent failure to not pass 70 percent of the ADHC provider rate increases directly to the ADHC direct support workers in the form of a floor minimum of $9 per hour and in other wage and non-wage benefits and/or the $250 monthly bonus payments; or

d. failure to provide LDH with any requested documentation or information related to or for the purpose of verifying compliance with this Rule.

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, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:383 (March 2024).

Subpart 5. Supports Waiver

Chapter 53. General Provisions

§5301. Purpose

A. The mission of this waiver is to create options and provide meaningful opportunities that enhance the lives of individuals with intellectual and/or developmental disabilities through employment and day service supports in the community. The goals of the supports waiver are as follows:

1. promote independence for beneficiaries with a developmental disability who are aged 18 years or older while ensuring health and safety through a system of beneficiary safeguards;

2. provide an alternative to institutionalization and costly comprehensive services through the provision of an array of services and supports that promote community inclusion and independence by enhancing and not replacing existing informal networks; and

3. increase high school to community transition resources by offering supports and services to those 18 years and older.

B. Allocation of Waiver Opportunities. The Office for Citizens with Developmental Disabilities (OCDD) maintains the developmental disabilities request for services registry (DDRSR), hereafter referred to as "the registry," which identifies persons with intellectual and/or developmental disabilities who are found eligible for developmental disabilities services using standardized tools, and who request waiver services.

1. Services are accessed through a single point of entry in the local governing entity (LGE). When criteria are met, individuals' names are placed on the registry and a screening of urgency of need (SUN) is completed.

2. Individuals determined to have current unmet needs as defined as a SUN score of urgent [three] or emergent [four] are offered a waiver opportunity.

3. The registry is arranged by the urgency of need and date of application for developmentally disabled (DD) waiver services.

4. OCDD waiver opportunities shall be offered based on the following priority groups:

a. Individuals living at publicly operated intermediate care facilities for the developmentally disabled (ICF/IIDs) or who lived at a publically operated ICF/IID when it was transitioned to a private ICF/IID through a cooperative endeavor agreement (CEA facility), or their alternates. Alternates are defined as individuals living in a private ICF/IID who will give up the private ICF/IID bed to an individual living at a publicly operated ICF/IID or to an individual who was living in a publicly operated ICF/IID when it was transitioned to a private ICF/IID through a cooperative endeavor agreement. Individuals requesting to transition from a publicly operated ICF/IID are awarded a slot when one is requested, and their health and safety can be assured in an OCDD waiver. This also applies to individuals who were residing in a publicly operated facility at the time the facility was privatized and became a CEA facility.

b. Individuals on the registry who have a current unmet need as defined by a SUN score of urgent [three] or emergent [four] and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available and a waiver offer is available.

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 32:1604 (September 2006), amended LR 40:2583 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2531 (December 2017), LR 48:1574 (June 2022), LR 50:211 (February 2024).

§5303. Settings for Home and Community-Based Services

A. Supports Waiver beneficiaries are expected to be integrated in and have full access to the greater community while receiving services, to the same extent as individuals without disabilities. Providers shall meet the requirements of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' (CMS) home and community-based setting requirements for home and community-based services (HCBS) waivers as delineated in LAC 50:XXI.901.

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HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1574 (June 2022).

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LOUISIANA DEPARTMENT OF HEALTH

ADULT DAY HEALTH CARE WAIVER (ADHC)

Chapter Nine of the Medicaid Services Manual

Issued October 18, 2013

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

State of Louisiana
Bureau of Health Services Financing

ADULT DAY HEALTH CARE WAIVER

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OVERVIEW

The Adult Day Health Care (ADHC) Waiver is a Medicaid Home and Community-Based Services (HCBS) Waiver program that expands the array of services available to individuals with functional impairments, and helps to bridge the gap between independence and institutional care by allowing them to remain in their own homes and communities.

This provider manual chapter specifies the requirements for reimbursement for services provided through an approved waiver of the Title XIX regulations. This document is a combination of federal and state laws and Louisiana Department of Health (LDH) policy which provides direction for provision of these services to eligible individuals in the State of Louisiana.

These regulations are established to assure minimum compliance under the law, equity among those served, provision of authorized services and proper fund disbursement. Should a conflict exist between manual chapter material and pertinent laws or regulations governing the Louisiana Medicaid Program, the latter will take precedence.

This manual chapter is intended to provide ADHC Waiver providers and support coordination agencies with the information necessary to fulfill its vendor contract with the State of Louisiana, and is the basis for federal and state reviews of the program. Full implementation of these regulations is necessary for a provider or agency to remain in compliance with federal and state laws and department rules.

Providers should refer to the General Information and Administration manual chapter of the *Medicaid Services Manual* located on the Louisiana Medicaid website at: http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf, for general information concerning topics relative to Medicaid provider enrollment and administration.

The LDH Bureau of Health Services Financing (BHSF), Office of Aging and Adult Services (OAAS), and Health Standards Section (HSS) are responsible for assuring oversight of the waiver services, licensing and enforcement, program monitoring, and compliance with the applicable rules and regulations.

Waiver services to be provided are specified in each beneficiary's person-centered Plan of Care (POC) which is written by the support coordinator based on input from the planning team. The planning team is comprised of the beneficiary, the support coordinator, and in accordance with the beneficiary's preferences, members of the family/natural support system, appropriate professionals and others whom the beneficiary chooses. The POC contains all services and activities involving the beneficiary, non-waiver as well as waiver services. Beneficiaries are to receive those waiver services included in the POC and approved by the appropriate support coordination designee or OAAS regional office (as applicable). Notification of approved services

is forwarded to the provider by the support coordinator, and the data contractor issues prior authorization to the providers based on the approved POC.

The number of persons approved for waiver participation each year is limited to the number of unduplicated beneficiaries authorized by the waiver agreement with the Centers for Medicare and Medicaid Services (CMS).

COVERED SERVICES

This section provides information about the services that are covered in the Adult Day Health Care (ADHC) Waiver program. For the purpose of this policy, when reference is made to "individual" or "beneficiary", this includes that person's responsible representative(s), legal guardian(s) and/or family member(s), as applicable, who are assisting that person in obtaining services.

Support Coordination

Support coordination, also referred to as case management, is a mandatory service designed to assist beneficiaries in gaining access to necessary waiver and other State Plan services, as well as needed medical, social, educational, housing and other services, regardless of the funding source for these services. The core elements of support coordination include the following:

1. Intake;
2. Assessment and re-assessment;
3. Plan of care (POC) development and revision;
4. Follow-up /monitoring;
5. Critical incident management; and
6. Transition/discharge and closure.

Support coordination agencies shall also be responsible for assessing, addressing and documenting delivery of services, including remediation of difficulties encountered by beneficiaries in receiving direct services.

Support coordination agencies shall not refuse to serve, or refuse to continue to serve, any individual who chooses/has chosen their agency unless there is documentation to support an inability to meet the individual's health and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. The Office of Aging and Adult Services (OAAS) must be immediately notified of the circumstances surrounding a refusal to provide/continue to provide services. This requirement can only be waived by OAAS.

Support coordination agencies must establish and maintain effective communication and good working relationships with beneficiaries' service providers.

Transition Intensive Support Coordination (TISC)

TISC is a service that assists individuals who are currently residing in nursing facilities who want to transition into the community. This service assists individuals in gaining access to needed waiver and other Medicaid State Plan services, as well as needed medical, social, housing, educational and other services, regardless of the funding source for these services.

Support coordinators shall comply with all of the requirements described above under the "Support Coordination" section. Support coordinators shall initiate and oversee the process for assessment and re-assessment, as well as be responsible for ongoing monitoring of the provision of services included in the beneficiary's approved POC. (See Appendix F for a complete list of the ADHC Waiver services available during the transition process).

Service Exclusions

Support coordination agencies are not allowed to bill for TISC until after the individual has been approved for the ADHC Waiver.

The scope of TISC shall not overlap with the scope of support coordination; therefore, duplicate billing is not allowed.

Service Limitations

Support coordination agencies may be reimbursed up to six (6) months (not to exceed 180 calendar days) from the POC approval date so long as the beneficiary is residing in the nursing facility. Reimbursement is contingent upon the support coordinator performing activities necessary to arrange for the individual to live in the community. These activities must be documented by the support coordinator. Support coordination agencies will not receive reimbursement for any month during which no activity was performed and documented in the transition process.

Transition Services

Transition services assist an individual, who has been approved for an ADHC opportunity, to leave a nursing facility and return to live in the community.

Transition Services are time limited, non-recurring set-up expenses available for individuals who have been offered and approved for an ADHC Waiver opportunity and are transitioning from a nursing facility to their own living arrangement in a private residence where the individual is directly responsible for their own living expenses. Transition services may also be used to purchase essential items needed for the individual even when the individual is residing with others. Allowable expenses are those necessary to enable the individual to establish a basic household,

excluding expenses for room and board. These services must be identified and approved in the individual's POC in accordance with the Louisiana Department of Health (LDH) and OAAS policies and procedures.

Transition services include the following:

1. Security deposits that are required to obtain a lease on an apartment or house;

2. Specific set-up fees or deposits for:

    a. Telephone;

    b. Electricity;

    c. Gas;

    d. Water; and

    e. Other such necessary housing start-up fees or deposits, including outstanding balances for past due charges and/or fees.

3. Activities to assess need, arrange for and procure needed resources (e.g. – fees associated with obtaining photo IDs or vital records, housing application fees, etc.);

4. Essential furnishings to establish basic living arrangements:

    a. Living Room – sofa/love seat, chair, coffee table, end table and recliner;

    b. Dining Room – dining table and chairs;

    c. Bedroom – bedroom set, mattress/box spring, bed frame, chest of drawers, nightstand, comforter, sheets, pillows, lamp and telephone;

    d. Kitchen – refrigerator, stove, cook top, dishwasher, convection oven, dishes/plates, glassware, cutlery/flatware, microwave, coffee maker, toaster, crock pot, indoor grill, pots/pans, drain board, storage containers, blender, can opener, food processor, mixer, dishcloths, towels and potholders;

    e. Bathroom – towels, hamper, shower curtain and bath mat;

    f. Miscellaneous - window coverings, window blinds, curtain rod, washer,

dryer, vacuum cleaner, air conditioner, fan, broom, mop, bucket, iron and ironing board; and

g. Moving Expenses – moving company and cleaners (prior to move, onetime expense).

5. Health and welfare assurances:

a. Pest control/eradication;

b. Fire extinguisher;

c. Smoke detector; and

d. First aid supplies/kit.

NOTE: Support coordinators must exhaust all other resources to obtain these items prior to utilizing the waiver.

Service Exclusions

Transition services do not include the following:

1. Monthly rent payments;

2. Mortgage payments;

3. Food;

4. Monthly utility charges; and

5. Household appliances and/or items intended solely for diversionary/recreational purposes (e.g. television, stereo, computer, etc.).

These services do not constitute room and board. These services may not be used to pay for furnishing or to set-up living arrangements that are owned or leased by a waiver provider.

Service Limitations

There is a $1,500 lifetime maximum limit per individual. Services must be prior approved by the OAAS regional office or its designee and require prior authorization (PA).

NOTE: This is the only waiver service that is NOT subject to the individual's annual POC maximum cost.

When the individual transitions to a home/apartment that is inhabited with another person, services will only be available for items that are to be used exclusively by the individual.

The purchaser for these items may be the individual, the responsible representative, the direct service provider, the support coordination agency, or any other source. However, the support coordination agency is the **ONLY** source that can bill for these services.

Adult Day Health Care Services

ADHC services provide planned, diverse daily program of individual services and group activities structured to enhance the beneficiary's physical functioning and to provide mental stimulation. ADHC services are furnished as specified in the POC at an ADHC center, in a licensed non-institutional, community-based setting encompassing both health/medical and social services needed to ensure the optimal functioning of the beneficiary.

An ADHC center shall, at a minimum, furnish the following services in accordance with licensing regulations:

1. Training or assistance with activities of daily living (toileting, grooming, eating, ambulation, etc.);

2. Health and nutrition counseling;

3. Individualized daily exercise program;

4. Individualized goal-directed recreation program;

5. Health education;

6. Medical care management;

7. One nutritionally-balanced hot meal and a minimum of two snacks served each day;

   NOTE: A provider may serve breakfast in place of a mid-morning snack. Also, providers must allow flexibility with their food and dining options to reasonably accommodate participants' expressed needs and preferences.

8. Nursing services that are provided by licensed nursing professionals and that include the following individualized health services:

a. Monitoring vital signs appropriate to the diagnosis and medication regimen of each beneficiary no less frequently than monthly;

b. Administering medications and treatments in accordance with physicians' orders;

c. Developing and monitoring beneficiaries' medication administration plans (self-administration and staff administered) of medications while the beneficiary is at the ADHC center; and

d. Serving as a liaison between the beneficiary and medical resources including the treating physician.

NOTE: All nursing services shall be provided in accordance with professional practice standards and all other requirements identified in the ADHC Licensing rules.

9. Transportation between the beneficiary's place of residence and the ADHC center at the beginning and end of the program day:

   a. The cost of transportation is included in the rate paid to ADHC centers. The beneficiary and their family may choose to transport the beneficiary to the ADHC center. Transportation provided by the beneficiary's family is not a reimbursable service.

   NOTE: An ADHC center may serve a person residing outside of the ADHC's licensed region; however, transportation by the ADHC center is not required.

10. Transportation to and from medical and social activities when the beneficiary is accompanied by ADHC center staff.

Service Exclusions

ADHC providers shall not bill for this service until after the individual has been approved for the ADHC Waiver.

Service Limitations

These services must be provided in the ADHC center that has been chosen by the beneficiary.

ADHC services are furnished on a regularly scheduled basis, not to exceed 10 hours a day, 50 hours per week (exclusive of transportation time to and from the ADHC center), as specified in the beneficiary's POC and ADHC ISP.

ADHC Waiver beneficiaries must attend a minimum of 36 days per calendar quarter, absent extenuating circumstances. The assigned support coordinator, based upon guidance provided by OAAS, must approve exceptions for extenuating circumstances.

ADHC Waiver and Long Term-Personal Care Services

ADHC Waiver beneficiaries may also be eligible to receive Long Term-Personal Care Services (LT-PCS), a Medicaid State Plan service, as long as the beneficiary also meets LT-PCS requirements. Eligibility for LT-PCS is based on the beneficiary's assessment score, which must identify a need of limited assistance or more in the performance of at least one (1) Activities of Daily Living (ADL). For additional information on LT-PCS, refer to Medicaid Provider Manual (Chapter 30) - Personal Care Services.

Hospice and Waiver Services

Beneficiaries who elect hospice services may choose to elect ADHC Waiver and hospice services concurrently. The hospice provider and support coordination agency must coordinate ADHC Waiver and hospice services when developing the beneficiary's POC. All core hospice services must be provided in conjunction with ADHC Waiver services.

When electing both services, the hospice provider must develop the POC with the beneficiary, the beneficiary's caregiver and the support coordination agency. The POC must clearly and specifically detail the ADHC Waiver and hospice services that are to be provided along with the frequency of services by each provider to ensure that services are non-duplicative, and the beneficiary's daily needs are being met. This will involve coordinating services where the beneficiary may receive services each day of the week.

The hospice provider shall be licensed by LDH-HSS and must provide all hospice services as defined in 42 CFR Part 418 which includes nurse, physician, hospice aide/homemaker services, medical social services, pastoral care, drugs and biologicals, therapies, medical appliances and supplies, and counseling in accordance with hospice licensing regulations.

Once the hospice program requirements are met, ADHC Waiver Services and LT-PCS (if applicable) can be utilized for those personal care tasks with which the beneficiary requires assistance.

Waiver Services Payable While in a Nursing Facility/Hospital

Certain ADHC Waiver services are payable when transitioning from a nursing facility or for a beneficiary during a temporary stay in a nursing facility/hospital. (See Appendix F for a complete list of the ADHC Waiver services).

BENEFICIARY REQUIREMENTS

The Adult Day Health Care (ADHC) Waiver program is only available to individuals who meet all the following criteria:

1. Medicaid financial eligibility;

2. Age 65 years or older, **OR** 22 through 64 years of age with a physical disability that meets Medicaid standards or the social Security Administration's disability criteria;

3. Nursing facility level of care requirements;

4. Name on the Request for Services Registry (RFSR)for the ADHC Waiver; and

5. A plan of care (POC) sufficient to:

    a. Reasonably assure that the health and welfare of the waiver applicant can be maintained in the community with the provision of waiver services; and

    b. Justify that the ADHC Waiver services are appropriate, cost effective and represent the least restrictive environment for the individual.

Failure of the individual to cooperate in the eligibility determination process or to meet any of the criteria above will result in the denial of admission or discharge from the ADHC Waiver.

Beneficiaries in the ADHC Waiver must attend a minimum of 36 days per calendar quarter, absent extenuating circumstances. The assigned support coordinator, based upon guidance provided by OAAS, must approve exceptions for extenuating circumstances.

NOTE: An individual may only be certified to receive services from one Home and Community-Based Services (HCBS) Waiver at a time.

Request for Services Registry

The Louisiana Department of Health (LDH) is responsible for the RFSR, hereafter referred to as "the registry," for the ADHC Waiver. An individual who wishes to have their name placed on the registry shall contact a toll-free telephone number which is maintained by the Office of Aging and Adult Services (OAAS).

Requests for ADHC Waiver services shall be accepted from the following:

1. The applicant;

2. An individual who is legally responsible for the applicant; or

3. A responsible representative designated by the applicant to act on their behalf.

Individuals will be screened and/or assessed to determine whether they meet nursing facility level of care and are members of the target population. Only individuals who meet these criteria will be added to the registry. The individual's name is placed on the registry in request date order.

NOTE: If at any time individuals do NOT meet nursing facility level of care, their names will be removed from the ADHC Waiver registry.

ADHC Waiver opportunities shall be offered to individuals on the registry according to priority groups. The following groups shall have priority for ADHC Waiver opportunities in the order listed:

1. Individuals with substantiated cases of abuse or neglect with Adult Protective Services (APS) or Elderly Protective Services (EPS) and who, absent ADHC Waiver services would require institutional placement to prevent further abuse and neglect as determined by OAAS review;

2. Individuals who have been discharged after a hospitalization within the past 30 calendar days that involved a stay of at least one night;

3. Individuals admitted to, or residing in, a nursing facility who have Medicaid as the sole payer source for the nursing facility stay; and

4. All other eligible individuals on the RFSR, by date of first request for services.

If an applicant is determined to be ineligible for any reason at the time an offer is made, the next individual on the registry, based on the above stated priority group, 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.

Admission Denial or Discharge Criteria

Failure of the individual to cooperate in the eligibility determination process or to meet any of the following criteria will result in denial of admission to/discharge from the ADHC Waiver:

1. The individual does not meet the target population criteria;

2. The individual does not meet the criteria for Medicaid eligibility;

3. The individual does not meet the criteria for a nursing facility level of care;

4. The beneficiary resides in another state or has a change of residence to another state;

5. Continuity of services is interrupted as a result of the beneficiary not receiving and/or refusing ADHC Waiver services (exclusive of support coordination services) for a period of 30 consecutive days;

   NOTE: Continuity of services will not apply when interruptions are due to a beneficiary being admitted to an acute care hospital, rehabilitation hospital or nursing facility. This exception is granted by OAAS and will typically not exceed 90 consecutive days.

6. The health and welfare of the individual cannot be reasonably assured through the provision of the ADHC Waiver services;

7. The individual fails to cooperate in the eligibility determination process or in the development/performance of the POC;

8. It is not cost effective to serve the individual in the ADHC Waiver;

9. The beneficiary fails to attend the ADHC center for a minimum of 36 days per calendar quarter; or

10. The individual fails to maintain a safe and legal home environment.

Involuntary discharge/transfer from the ADHC center or ADHC Waiver program may occur for one of the following:

1. Medical protection or the well-being of the individual or others;

2. Emergency situation (i.e., declared or non-declared disasters affecting the ADHC);

3. Health or welfare of the beneficiary is threatened; or

4. Inability of the ADHC provider to furnish the services indicated in the beneficiary's POC after documented reasonable accommodations have failed.

BENEFICIARY RIGHTS AND RESPONSIBILITIES

Beneficiaries have specific rights and responsibilities that accompany eligibility and participation in the Medicaid and Medicaid waiver programs. Support coordinators and service providers must assist beneficiaries to exercise their rights and responsibilities. Every effort must be made to assure that applicants or beneficiaries understand their available choices and the consequences of those choices. Support coordinators and service providers are bound by their provider agreement with Medicaid to adhere to the following policies on beneficiary rights.

Each individual who requests Adult Day Health Care (ADHC) Waiver services has the option to designate a responsible representative to assist or act on their behalf in the process of accessing and/or maintaining ADHC Waiver services. The beneficiary has the right to change their responsible representative at any time. The responsible representative may not concurrently serve as a responsible representative for more than two (2) beneficiaries in a Medicaid Home and Community-Based Services (HCBS) program that is operated by the Office of Aging and Adult Services (OAAS) (unless an exception is granted by OAAS) which includes, but is not limited to the following:

1. Program of All-Inclusive Care for the Elderly (PACE);
2. Long Term - Personal Care Services (LT-PCS);
3. Community Choices Waiver (CCW); and
4. ADHC Waiver.

Freedom of Choice of Program

Individuals who have been offered waiver services have the freedom to select between institutional care services and HCBS. They are informed of their alternatives under the waiver at the time they are going through the Medicaid application and determination process. These individuals have the responsibility to participate in this process which includes providing medical and other pertinent information or assisting in obtaining this information to be used in the person-centered planning and service approval process. When applicants are admitted to the waiver, they have access to an array of Medicaid services.

Freedom of Choice of Agencies/Providers

Beneficiaries have the freedom of choice to select their support coordination agency/providers. Beneficiaries may make agency/provider changes based on the following schedule:

Type of Service	Without Good Cause	With Good Cause
Support Coordination Transition Intensive Support Coordination	Beneficiaries must have been with the support coordination agency at least six (6) months	Any time
Adult Day Health Care (ADHC)	Once every six (6) months with the change effective beginning the first day of the following calendar quarter	Any time
Transition Service	Not Applicable	Not Applicable

Good cause is defined as:

1. A beneficiary moving to another region in the state where the current provider/agency does not provide services;

2. The beneficiary and the provider/agency have unresolved difficulties and mutually agree to a transfer;

3. The beneficiary's health or welfare has been compromised; or

4. The provider/agency has not rendered services in a manner satisfactory to the beneficiary.

Support coordinators will provide beneficiaries their choice of ADHC providers and help arrange and coordinate the services on the Plan of Care (POC).

The OAAS, or its designee will provide beneficiaries with their choice of support coordination agencies.

Adequacy of Care

All beneficiaries in HCBS waiver programs inclusive of ADHC services have the right to choose and receive the services necessary to support them to live in a community setting. Beneficiaries have the right to choose how, where, and with whom they live. Services are arranged and coordinated through support coordination and approved by the OAAS regional office or its designee. Administrative limits are placed on some services according to the waiver that is authorized by the Center for Medicare and Medicaid Services (CMS).

Beneficiaries have the responsibility to request only those services they need and not request excess services, or services for the convenience of employees, providers or support coordinators. Units of service are not "saved up". The services are certified as medically necessary for the beneficiary to be able to stay in the community and are revised on the POC as each beneficiary's needs change. The support coordinator must be informed anytime there is a change in the beneficiary's health, medication, physical conditions, and/or living situation.

Participation in Care

Each beneficiary shall participate in the assessment, person-centered planning meetings and any other meeting involving decisions about services and supports to be provided as part of the waiver process. Each beneficiary may choose whether or not providers attend assessment and planning meetings. Person-centered planning will be utilized in developing all services and supports to meet the beneficiary's needs. By taking an active part in planning their services, the beneficiary is better able to utilize the available supports and services. The beneficiary is expected to participate in the planning process to the best of the beneficiary's ability so that services can be delivered according the approved person-centered POC. The beneficiary shall report any service need change to their support coordinator and service provider(s).

Changes in the amount of services must be requested by the beneficiary and submitted to the support coordinator as soon as the need is identified. The support coordinator will prepare and submit the POC revision in accordance with the required timelines. Providers may not initiate requests for change/adjustment of service(s), or modifications to the POC, without the participation and consent of the beneficiary. The OAAS regional office or its designee must approve these changes.

Voluntary Participation

Beneficiaries have the right to refuse services, to be informed of the alternative services available to them, and to know the consequences of their decisions. Therefore, a beneficiary will not be required to receive services or participate in activities they do not want, even if they are eligible for those services. The intent of the ADHC Waiver is to provide community-based services to

individuals who would otherwise require care in a nursing facility.

Providers must reasonably assure that the beneficiary's health and welfare needs are met. As part of the planning process, methods to comply with these assurances may be negotiated to suit the beneficiary's needs.

Quality of Care

Each HCBS waiver beneficiary has the right to be treated with dignity and respect and receive services from provider employees who have been trained and are qualified to provide them. In addition, providers are required to maintain privacy and confidentiality in all interactions related to the beneficiaries' services.

Beneficiaries have the right to be free from abuse (mental, physical, emotional, coercion, restraints, seclusion, and any other forms of restrictive interventions).

In cases where services are not delivered according to the approved POC, or there are allegations of abuse, neglect, exploitation, or extortion, the beneficiary shall follow the reporting procedures and inform the support coordinator, provider, and appropriate authorities.

Beneficiaries and providers shall cooperate in the investigation and resolution of reported critical incidents/complaints.

Beneficiaries must maintain a safe and lawful home environment and may not request providers to perform tasks that are illegal or inappropriate, and they may not violate the rights of other beneficiaries.

Civil Rights

Providers shall operate in accordance with Title VI and VII of the Civil Rights Act of 1964, as amended and the Vietnam Veterans Readjustment Act of 1974 and all requirements imposed by or pursuant to the regulations of the U.S. Department of Health and Human Services (DHHS). This means that individuals are accepted and that all services and facilities are available to persons without regard to race, color, religion, age, sex, or national origin. Beneficiaries have the responsibility to cooperate with their providers by not requesting services which in any way violate these laws.

Notification of Changes

The Bureau of Health Services Financing (BHSF) is responsible for determining financial eligibility for the ADHC Waiver beneficiaries. In order to maintain eligibility, beneficiaries and

providers have the responsibility to inform BHSF of changes in the beneficiary's income, resources, address, and living situation.

OAAS or its designee is responsible for approving level of care and medical certification. Beneficiaries and their providers have the responsibility to inform OAAS of any changes which affect programmatic waiver eligibility requirements, including changes in level of care.

Grievances/Complaints

The beneficiary has a responsibility to bring problems to the attention of providers or the Medicaid program and to file a grievance/complaint without fear of retribution, retaliation, or discharge.

All support coordination and providers must have grievance procedures through which beneficiaries may voice complaints regarding the supports or services they receive. Beneficiaries must be provided a copy of the grievance procedures upon admission to a provider and complaint/grievance forms shall be given to beneficiaries thereafter upon request. It is the beneficiary's right to contact any advocacy resource as needed, especially during grievance procedures.

If beneficiaries need assistance, clarification, or to report a complaint, toll-free numbers are available (See Appendix A for contact information).

Fair Hearings

Beneficiaries must be advised of their rights to appeal any agency action or decision resulting in suspension, reduction, discontinuance, or termination of services. Beneficiaries have the right to a fair hearing through the Division of Administrative Law (DAL). In the event of a fair hearing, a representative of the service provider and support coordination agency must participate by telephone or in person, if requested.

An appeal by the beneficiary may be filed with DAL via fax, mail, online request, or by telephone. (See Appendix A for contact information). Instructions for submitting appeal request are also included in all adverse action notices.

Rights and Responsibilities Form

The support coordinator is responsible for reviewing the beneficiary's rights and responsibilities with the beneficiary and their responsible representative as part of the initial intake process and at least annually thereafter. (See Appendix B for information on accessing the *Office of Aging and Adult Services (OAAS) Rights and Responsibilities for Applicants/Participants of Home and Community-Based Services (HCBS) Waiver* form).

SERVICE ACCESS AND AUTHORIZATION

When funding is appropriated for a new Adult Day Health Care (ADHC) Waiver opportunity or an existing opportunity is vacated, the individual who meets criteria for the priority group, or whose date is reached on the ADHC Waiver Request for Services Registry (RFSR), shall receive a written notice indicating that a waiver opportunity is available. The applicant will receive a waiver offer packet that includes an ADHC Waiver Services Decision Form and a Support Coordination Agency Freedom of Choice (FOC) and Release of Information form.

The applicant must complete and return the packet if interested in accepting the ADHC Waiver opportunity and to determine if they meet the preliminary level of care and/or any additional program requirements.

If the applicant meets the preliminary level of care and/or additional program requirements, they will be linked to a support coordination agency. A support coordinator will be assigned to conduct an in-home assessment with the applicant and inform them of all available services. The support coordinator shall also assist the applicant as needed with the financial eligibility process conducted by the Medicaid eligibility office.

Once it has been determined that the applicant meets the level of care requirements for the program, a second home visit is made to finalize the plan of care (POC). The following must be addressed in the POC:

1. The types and number of services (including waiver and all other services) necessary to reasonably assure health and welfare and to maintain the beneficiary safely in the community;

2. The individual cost of each waiver service; and

3. The total cost of waiver services covered by the POC.

Provider Selection

The support coordinator must present the beneficiary with a list of providers who are enrolled in Medicaid to provide those services that have been identified on the POC. The support coordinator will have the beneficiary or responsible representative complete the provider FOC list. FOC will be offered initially and annually thereafter for each identified waiver service.

The support coordinator is responsible for the following:

1. Notifying the selected provider that they have been chosen by the beneficiary to provide the necessary services;

2. Completing assessments and POCs;

3. Obtaining an agreement to provide services and copies of any completed assessments and/or plans written by the provider; and

4. Forwarding the POC packet to the Office of Aging and Adult Services (OAAS) regional office or its designee, as applicable for review and approval following the established protocol.

NOTE: Authorization to provide service is always contingent upon having an approved POC or POC revision.

Prior Authorization

All services under the ADHC Waiver must be prior authorized. Prior authorization (PA) is the process to approve specific services for a Medicaid beneficiary by an enrolled Medicaid provider prior to service delivery and reimbursement. The purpose of PA is to validate the service requested as medically necessary and that it meets criteria for reimbursement. PA does not guarantee payment for the service as payment is contingent upon the passing of all edits contained within the claims payment process, the beneficiary's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and the ongoing medical necessity for the service.

The PA is performed by the Medicaid data contractor and is specific to a beneficiary, provider, service code, established quantity of units, and for specific dates of service.

The PA revolves around the POC document, which means that only the service codes and units specified in the approved POC will be prior authorized. Services provided without a current PA are not eligible for reimbursement. There will be no exceptions made for reimbursement of services performed without a current PA.

The ADHC provider is responsible for the following activities:

1. Developing an Individual Service Plan (ISP) in accordance with the approved POC and as stipulated in the ADHC licensing regulations and Medicaid certification rules (LAC 50. XXI.2303. A.);

2. Checking PAs to verify that they match the approved services in the beneficiary's POC and any mistakes must be immediately corrected;

3. Verifying that services were documented as evidenced by time entries, attendance records, progress notes and progress summaries and are within the approved service limits as identified in the beneficiary's POC prior to billing for the service;

4. Verifying that services were delivered according to the beneficiary's approved POC prior to billing for the service;

5. Proper use of the Electronic Visit Verification (EVV) system;

6. Inputting the correct date(s) of service, authorization numbers, provider number, and beneficiary number in the billing system;

7. Billing only for the services that were delivered to the beneficiary and are approved in the beneficiary's POC;

8. Reconciling all remittance advices issued by the Louisiana Department of Health (LDH) fiscal intermediary with each payment; and

9. Checking billing records to ensure that the appropriate payment was received.

NOTE: Providers have one-year timely filing billing requirement under Medicaid regulations. See Section 1.4, Timely Filing Guidelines in Chapter General Information and Administration of the *Medicaid Services Manual* at: http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf

Support Coordination

The data contractor issues authorizations for support coordination service for the POC year. A service unit is one month and each authorization covers a maximum of seven months, or seven service units. Typically, two PAs will be issued for a one year POC. At the end of each month, after the support coordination agency fulfills the service requirements and inputs the required documentation in the case management database, the data contractor will release one service unit of the PA.

Transition Intensive Support Coordination (TISC)

Authorization for TISC is issued upon receipt of the POC (provisional or initial). A service unit is one month. The authorization includes a unit of service for each month with a maximum of six (6) units of service per authorization. At the end of each month, after the support coordination agency fulfills the service requirements and inputs the required documentation in the case management database, the data contractor will release one service unit of the PA.

NOTE: Authorization for services will not be issued retroactively unless a person leaving a facility is involved with special circumstances as determined and approved by OAAS.

Transition Services

Authorization for Transition Services has a lifetime cap of $1,500. The authorization period is the effective date indicated on the POC or revision request through the POC end date. After the approved purchases are made, the POC (provisional, initial or revision) that includes the transition services, the receipts for the purchases and the "Transition Services Form" are sent to the data contractor. (See Appendix B for a copy of this form).

The data contractor issues and releases the PA to the support coordination agency upon receipt of complete and accurate information. The support coordination agency is responsible for reimbursing the purchaser (beneficiary, family, provider, own agency, etc.) upon receipt of reimbursement.

Adult Day Health Care Services

ADHC service units are 15 minutes. Adult Day Health Care (ADHC) services are assigned a PA number for the year. Approved units of service are issued on a quarterly basis. Units of service approved for one week cannot exceed established limits. For PA purposes, a week is defined as beginning at 12:00 a.m. Sunday and ending at 11:59 p.m. the following Saturday. Payment for services is capped at 50 hours per week and no more than 10 hours per day.

In the event that reimbursement is received without an approved PA, the amount paid is subject to recoupment.

Post Authorization

Some services require post authorization before the provider is able to bill for services rendered. Post authorization may occur either through EVV or documentation submitted by the support coordinator.

EVV	Additional Documentation
Adult Day Health Care (ADHC)	Transition Services

The data contractor checks the information reported against the prior authorized units of service. Once post authorization is granted, the service provider may bill the LDH fiscal intermediary for the appropriate units of service.

Providers must use the correct PA number when filing claims for services rendered. Claims with the incorrect PA number will be denied.

Changing ADHC Providers

Beneficiaries or their responsible representative must request any change in amount(s) of service/units to the support coordinator.

All requests for changes in ADHC providers require a new Freedom of Choice by the beneficiary or their responsible representative. (Refer to 9.3- Beneficiary Rights and Responsibilities, Freedom of Choice of Agencies/Providers, for details on "good cause" criteria and timelines).

The support coordinator will provide the beneficiary with the current FOC list of ADHC providers. Once a new provider has been selected, the support coordinator will ensure the new provider is notified of the request. With written consent from the beneficiary, both the transferring and receiving providers share responsibility for ensuring the exchange of medical and program information which includes the following:

1. Progress notes from the last six (6) months, or if the beneficiary has received services from the provider for less than six (6) months, all progress notes from date of admission;

2. Written documentation of services provided, including monthly and quarterly progress summaries;

3. Current ISP;

4. Current assessments upon which the ISP is based;

5. A summary of the beneficiary's behavioral, social, health and nutritional status;

6. Records tracking beneficiary's progress towards ISP goals and objectives;

7. Documentation of the amount of authorized services remaining in the POC, including direct service case record documentation; and

8. Documentation of exit interview.

The support coordinator will facilitate the transfer of the above referenced information to the receiving ADHC provider and forward copies of the following to the new ADHC provider:

1. Most current POC;

2. Current assessments on which the POC is based;

3. Number of services used in the calendar year; and

4. All other waiver documents necessary for the new ADHC provider to begin providing services.

NOTE: The new ADHC provider must bear the cost of copying which cannot exceed the community's competitive copying rate.

Prior Authorization for New ADHC Providers

The support coordinator will complete POC revision that includes the start date for the new provider and the end date for the transferring provider. A new PA will be issued to the new provider with an effective starting date as indicated on the POC revision. The transferring provider's PA number will expire on the end date as indicated on the POC revision.

Changing Support Coordination Agency

A beneficiary may change to a different support coordination agency for any reason after being with that agency for six (6) months, or at any time for good cause, as long as the new agency has not met its maximum number of beneficiaries, and as approved by the OAAS regional office or its designee.

Good cause is defined as the following:

1. A beneficiary moving to another region in the state;

2. The beneficiary and the support coordination agency have unresolved difficulties and mutually agree to a transfer;

3. The beneficiary's health, safety or welfare has been compromised; or

4. The support coordination agency has not rendered services in a manner satisfactory to the beneficiary.

After the beneficiary has selected and been linked by the data contractor to a new support coordination agency, the new agency must inform the transferring agency and complete the FOC file transfer. The new agency must obtain the case record and authorized signature, and inform the transferring agency.

Upon receipt of the completed form, the transferring agency must have provided copies of the following information to the new agency:

1. Most current POC;

2. Current assessments on which the POC is based;

3. Number of services used in the POC year; and

4. Most recent six (6) months of progress notes.

NOTE: The new support coordination agency must bear the cost of copying which cannot exceed the community's competitive copying rate. If the new agency does not receive the information in a timely fashion, the appropriate OAAS regional office should be contacted for assistance.

The transferring support coordination agency must provide services up to the transfer of records and is eligible to bill for support coordination services for the month in which the dated notification is received (transfer of records) by the receiving agency.

In the month the transfer occurs, the receiving agency shall begin services within three (3) days after the transfer of records and is eligible to bill for services the first full month after the transfer of records. Immediately after the transfer of records, the receiving agency must submit the required documentation to the data contractor to obtain prior authorization.

Prior Authorization for New Support Coordination Agency

A new PA number will be issued to the new support coordination agency with an effective starting date as the first day of the first full calendar month following the date of the transfer of the records. The transferring agency's PA number will expire on the date of the transfer of the records.

OAAS or its designee will not backdate the new PA period to the first day of the calendar month in which the FOC and transfer of records are completed. If the new support coordination agency receives the records and admits a beneficiary in the middle of a month, they cannot bill for services until the first day of the next month.

PROVIDER REQUIREMENTS

Provider participation in the Louisiana Medicaid program is voluntary. In order to participate in the Medicaid Program, a provider must:

1. Meet all of the requirements, including licensure, as established by state laws and rules promulgated by the Louisiana Department of Health (LDH);

2. Agree to abide by all rules, regulations, policies and procedures established by the Centers for Medicare and Medicaid Services (CMS), LDH and other state agencies if applicable; and

3. Comply with all of the terms and conditions for Medicaid enrollment.

Providers should refer to the General Information and Administration manual chapter of the *Medicaid Services Manual* located on the Louisiana Medicaid website at: http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf. Section 1.1 - Provider Requirements contains detailed information concerning topics relative to Medicaid provider enrollment.

Providers must not have been terminated or actively sanctioned by Medicaid, Medicare or other health-related programs in Louisiana or any other state. The provider must not have an outstanding Medicaid Program audit exception or other unresolved financial liability owed to the state.

Providers must document that criminal record history checks have been obtained and that employees and the employees of subcontractors do not have a criminal record as defined in R.S. 40:1203.1 et seq. Providers are not to employ individuals who have been convicted of abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual. Providers must determine whether applicants for employment have histories indicating involvement in abuse, neglect or mistreatment, or a criminal record involving physical harm to an individual.

Failure to comply with these licensing regulations may result in any or all of the following:

1. Recoupment;

2. Sanctions;

3. Loss of enrollment; or

4. Loss of licensure.

Providers must also check the certified nursing assistant (CNA) and direct service worker (DSW) Registries for placement of findings of abuse, neglect, or misappropriation and shall be in accordance with licensing regulations.

Providers must attend all mandated meetings and training sessions as directed by LDH and/or its designee as a condition of enrollment and continued participation as a waiver provider. A provider enrollment packet must be completed for each LDH administrative region in which the agency or provider will deliver services. Providers will not be added to the Freedom of Choice (FOC) list of available providers until they have been issued a Medicaid provider number for that provider type.

Providers must participate in the initial training for prior authorization (PA) and data collection and any training provided on changes in the system. Initial training is provided at no cost to the agency. Any repeat training must be paid for by the requesting agency.

Providers must have available computer equipment, software, and internet connectivity necessary to participate in PA, data collection, and Electronic Visit Verification (EVV).

All brochures provided by the Adult Day Health Care (ADHC) provider must be approved by the Office of Aging and Adult Services (OAAS) prior to use.

Waiver services are to be provided strictly in accordance with the provisions of the approved plan of care (POC). Providers of ADHC services and support coordination agencies are obligated to immediately report changes to LDH that could affect the beneficiary's eligibility including, but not limited to, those changes cited in the denial or discharge criteria.

The beneficiary's support coordination agency and ADHC provider must have a written working agreement that includes the following:

1. Written notification of the time frames for POC planning meetings;

2. Timely notification of meeting dates and times to allow for provider participation;

3. Assurance that the appropriate provider representative is present at planning meetings as invited by the beneficiary; and

4. Information on how the agency is notified when a change occurs in the POC or service delivery.

ADHC providers are responsible for documenting the occurrence of incidents or accidents that affect the health, safety, and welfare of the beneficiary and completing an incident report. The incident report shall be submitted to OAAS, or its designee, with the specified requirements and timelines. (See Appendix B for information on accessing the *OAAS Critical Incident Reporting*

Policies and Procedures manual).

Each ADHC provider shall complete the LDH approved cost report and submit the cost report(s) to the designated LDH contractor on or before the last day of September following the close of the cost reporting period. (See Appendix A to obtain web address for additional information).

Licensure and Specific Provider/Agency Requirements

Providers, or agencies, must meet licensure and/or certification and other additional requirements as outlined in the tables below and in other sections of 9.5:

Support Coordination, Transition Intensive Support Coordination and Transition Services
Provided by a **support coordination agency** that: 1. Is certified by LDH /OAAS to provide support coordination services; 2. Has signed the OAAS Performance Agreement; 3. Has at least one support coordinator supervisor and one support coordinator who has passed the assessment and care planning certification training; 4. Has a brochure that has been approved by OAAS; 5. Has submitted a completed OAAS agency contact information form to OAAS; 6. Has enrolled as a Medicaid provider of support coordination services in all regions in which it intends to provide services; and 7. Is listed on the Support Coordination Agency FOC form.

Adult Day Health Care (ADHC)
Provided by an **ADHC provider** that: 1. Is licensed by the LDH Health Standards Section (HSS) as an ADHC provider in accordance with Louisiana Revised Statute 40:2120.47; 2. Has enrolled in Medicaid as an ADHC provider; and 3. Is listed on the ADHC FOC form. **NOTE:** Qualifications for ADHC staff are set forth in the licensing regulations found in the Louisiana Administrative Code.

Provider Responsibilities

Providers of ADHC Waiver services must abide by all staffing and training requirements and ensure that staff and supervisors possess the minimum requisite education, skills, qualifications, training, supervision and coverage as set forth by their respective licensing authorities and in accordance with all applicable LDH and OAAS rules and policies.

Providers shall not refuse to serve any beneficiary who chooses their agency, unless there is documentation to support an inability to meet the beneficiary's health and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services.

Refusal to serve a beneficiary must be put in writing by the provider to the support coordinator and the beneficiary. This written notice must provide a detailed explanation as to why the provider is unable to provide services to the beneficiary. Upon receipt of this written documentation, the support coordinator is to forward the notice to the OAAS regional office for approval/refusal.

Providers shall not interfere with the eligibility, assessment, care plan development, or care plan monitoring processes with use of methods including, but not limited to harassment, intimidation or threats against the beneficiary or members of the beneficiary's informal network, support coordination staff or employees of LDH.

Providers shall have the capacity and resources to provide all aspects of any service they are enrolled to provide in the specified service area.

If the provider proposes involuntary transfer of a beneficiary, discharge of a beneficiary or if a provider closes in accordance with licensing standards, the following steps must be taken:

1. The provider shall give written notice to the beneficiary, a family member and/or the responsible representative, if known, and the support coordinator at least 30 calendar days prior to the transfer or the discharge;

2. Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the beneficiary understands;

3. A copy of the written discharge/transfer notice shall be put in the beneficiary's record; and

4. When the safety or health of beneficiaries or provider staff is endangered, written notice shall be given as soon as possible before the transfer or discharge:

    a. The written notice shall include the following:

        i. A reason for the transfer or discharge;

        ii. The effective date of the transfer or discharge;

        iii. An explanation of a beneficiary's right to personal and/or third party

representation at all stages of the transfer or discharge process;

iv. Contact information for the Advocacy Center;

v. Names of provider personnel available to assist the beneficiary and family in decision making and transfer arrangements;

vi. The date, time, and place for the discharge planning conference;

vii. A statement regarding the beneficiary's appeal rights;

viii. The name of the director, current address and telephone number of the Division of Administrative Law; and

ix. A statement regarding the beneficiary's right to remain with the provider and not be transferred or discharged if an appeal is timely filed.

Provider transfer or discharge responsibilities shall include the following:

1. Developing a written report detailing the circumstances leading to any discharge;

2. Holding a transfer or discharge planning conference with the beneficiary, family, support coordinator, legal representative and advocate, if such is known;

3. Developing a discharge plan that specifies the beneficiary's needed supports and the resources available to them after discharge and includes options that will provide reasonable assurance that the beneficiary will be transferred or discharged to a setting that can be expected to meet their needs;

4. Providing all services required and contained in the final update of the service plan and in the transfer or discharge plan up until the transfer or discharge;

5. Coordinating and consulting with the receiving center or other program (if applicable) to discuss the beneficiary's needs as warranted; and

6. Preparing and submitting to the receiving center or program an updated discharge service plan and written discharge summary of the beneficiary's needs and health that shall include, at a minimum:

    a. Medical diagnoses;

    b. Medication and treatment history/regimen (current physician's orders);

c. Functional needs (inabilities);

d. Any special equipment utilized (dentures, ambulatory aids, eyeglasses, etc.);

e. Social data and needs;

f. Financial resources; and

g. Any other information which would enable the receiving ADHC center/caregiver(s) to provide the continued necessary care without interruption.

Support Coordination Agencies

Support coordination agencies must meet the following criteria:

1. Meet all of the requirements included in the OAAS support coordination performance agreement, the OAAS Home and Community-Based Services (HCBS) Waivers Support Coordination Standards for Participation rule, and comply with all LDH and OAAS policies and procedures;

2. Maintain a toll-free telephone line with 24-hour accessibility manned by an answering service. This toll-free number must be given to beneficiaries at intake or at the first meeting with the beneficiary;

3. Have brochures that provide information about their agency's experience, including the provider's toll-free number and the OAAS toll-free information number;

4. Assure staff attends all training mandated by OAAS;

5. Furnish information and assistance to beneficiaries in directing and managing their services; and

6. Provide the beneficiary's approved POC to the ADHC provider in a timely manner.

ADHC Providers

ADHC providers must have written policy and procedure manuals that include, but are not limited to the following:

1. Administrative: Employment and personnel job descriptions; hiring practices including a policy against discrimination; employee evaluation, promotion, disciplinary action, termination and hearing of employee grievances; staffing and staff coverage plan;

2. Employment Qualifications: Must possess direct care abilities, skills and knowledge to adequately perform care and assistance as required by waiver beneficiaries;

3. Training: Staff orientation in safety and emergency procedures as stipulated by LDH licensing and certification rules and regulations;

4. Records: Maintenance, security, supervision, confidentiality, organization, transfer and disposal;

5. Beneficiary Rights: Identification, notification and protection of beneficiary's rights both verbally and in writing in a language the beneficiary/family is able to understand;

6. Grievances: Written grievance procedures;

7. Abuse/Neglect: Information about abuse and neglect as defined by LDH regulations and state and federal laws; reporting responsibilities;

8. Discharges: Voluntary and involuntary discharges/transfers from their center; and

9. EVV: Requirements/proper use of check in/out; acceptable editing of electronically captured services; confidentiality of log in information; and monitoring for proper use.

ADHC providers must also:

1. Comply with all applicable LDH rules and regulations including the use of an approved Electronic Visit Verification (EVV) system;

2. Provide transportation to any beneficiary within their licensed region in accordance with ADHC licensing standards; and

3. Provide the beneficiary's approved Individualized Service Plan (ISP) to the support coordinator in a timely manner.

An ADHC Waiver beneficiary must attend the ADHC center a minimum of 36 days per calendar quarter, absent extenuating circumstances. An ADHC provider is not allowed to impose that beneficiaries attend a minimum number of days per week. A beneficiary's repeated failure to attend as specified in the POC may warrant a revision to the POC or possibly a discharge from the waiver. ADHC providers should notify the beneficiary's support coordinator when a beneficiary routinely fails to attend the ADHC as specified.

When an ADHC provider reaches licensed capacity, the OAAS regional office should be notified immediately. The center's name will be removed from the ADHC FOC until they notify the OAAS regional office that they are able to admit new beneficiaries.

An ADHC center shall employ a sufficient number of qualified staff and delegate sufficient authority to such staff to ensure that the ADHC's responsibilities are carried out and that the following functions are adequately performed:

1. Administrative;
2. Fiscal;
3. Clerical;
4. Housekeeping, maintenance and food service;
5. Direct services;
6. Supervision;
7. Record-keeping and reporting;
8. Social services; and
9. Ancillary services.

The ADHC provider shall ensure the following:

1. All non-licensed direct care staff members meet the minimum, mandatory qualifications and requirements for direct service workers as required by R.S. 40:2179-2179.1;
2. All staff members are properly certified and/or licensed as legally required;
3. An adequate number of qualified direct service staff is present with beneficiaries as

necessary to ensure the health and welfare of beneficiaries;

4. Procedures are established to assure adequate communication among staff in order to provide continuity of services to beneficiaries to include:

    a. Regular review of individual and aggregate problems of beneficiaries, including actions taken to resolve these problems;

    b. Sharing daily information, noting unusual circumstances and other information requiring continued action by staff; and

    c. Maintenance of all accidents, injuries, and incident records related to beneficiaries.

5. Employees working with beneficiaries have access to information from case records necessary for effective performance of the employees' assigned tasks;

6. A staff member who has knowledge of and can apply first aid and who is certified in CPR must be in the ADHC center at all times;

7. A staff member shall is designated to supervise the ADHC center in the absence of the director;

8. A written plan of emergency and safety procedures that includes training staff on their duties when responding to emergencies and evacuating beneficiaries to safe or sheltered areas; and

9. All furnishings and equipment are

    a. Kept clean;

    b. In good repair; and

    c. Appropriate for use by the beneficiaries in terms of comfort and safety.

Each ADHC provider shall ensure that its setting is integrated in and supports full access to the greater community including the option to seek employment in integrated settings if desired, engaging in community life, and to receive services in the community to the same degree of access as individuals not receiving Medicaid (HCBS.

Changes

The following changes are reported, in writing, to the Health Standards Section (HSS), OAAS and the fiscal intermediary's Provider Enrollment Section, within five (5) working days of the actual change:

1. Name of the ADHC center;
2. Physical location;
3. Mailing address;
4. Contact information (i.e. telephone number, fax number, email address); and
5. Key administrative staff (e. director, program manager, social service designee, RN/ LPN, etc.).

When a change of ownership (CHOW) occurs, the ADHC provider shall notify HSS in writing within 15 days prior to the effective date of the CHOW.

When an ADHC provider closes or decides to no longer participate in the Medicaid program, the provider must provide at least 30-day written advance notice to beneficiaries and their responsible representatives, support coordination agencies, and LDH (OAAS and HSS) prior to discontinuing service.

RECORD KEEPING

Providers should refer to the *Medicaid Services Manual*, Chapter 1 General Information and Administration, Section 1.1 - Provider Requirements for additional information of record keeping. (http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf)

NOTE: For this section 9.6-Record Keeping, the term "provider" is used to refer to either the ADHC provider or the support coordination agency.

Components of Record Keeping

All provider records must be maintained in an accessible, standardized order and format at the enrolled office site in the Louisiana Department of Health's (LDH) administrative region where the beneficiary resides. The provider must have sufficient space, facilities and supplies to ensure effective record keeping. The provider must keep sufficient records to document compliance with LDH requirements for the beneficiary served and the provision of services.

A separate record that supports justification for prior authorization and fully documents services for which payments have been made must be maintained on each beneficiary. The provider must maintain sufficient documentation to enable LDH or its designee to verify that prior to payment each charge is due and proper. The provider must make available all records that LDH or its designee, including the beneficiary's support coordination agency, finds necessary to determine compliance with any federal or state law, rule or regulation promulgated by LDH.

Retention of Records

The provider must retain administrative, personnel, and beneficiary records for a minimum of six (6) years from the date of the last payment period. If records are under review as part of a departmental or government audit, the records must be retained until all audit questions are answered and the audit is completed (even if that time period exceeds six (6) years).

NOTE: Upon provider closure, all records must be maintained according to applicable laws, regulations and the above record retention requirements and copies of the required documents transferred to the new provider.

Confidentiality and Protection of Records

Records, including administrative and beneficiary, must be the property of the provider and secured against loss, tampering, destruction or unauthorized use.

Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the provider, the beneficiaries or their families, directly or indirectly, to any unauthorized person. The provider must safeguard the confidentiality of any information that might identify the beneficiaries or their families. The information may be released only under the following conditions:

1. Court order;

2. Beneficiary's written informed consent for release of information;

3. Written consent of the individual to whom the beneficiary's rights have been devolved when the beneficiary has been declared legally incompetent; or

4. Compliance with the Federal Confidentiality Law of Alcohol and Drug Abuse Patients Records (42 CFR, Part 2).

Upon request, a provider must make available, information in the case records to the beneficiary or legally responsible representative. If, in the professional judgment of the administration of the agency, it is felt that information contained in the record would be damaging to the beneficiary, that information may be withheld from the beneficiary except under court order.

The provider may charge a reasonable fee for providing the above records. This fee cannot exceed the community's competitive copying rate.

A provider may use material from case records for teaching or research purposes, development of the governing body's understanding and knowledge of the provider's services, or similar educational purposes, if names are deleted and other similar identifying information is disguised or deleted.

Any electronic communication containing beneficiary specific identifying information sent by the provider to another provider or to LDH, must comply with regulations of the Health Insurance Portability and Accountability Act (HIPAA) and be sent securely via an encrypted messaging system.

Beneficiary records must be located at the enrolled site.

NOTE: Under no circumstances should providers allow staff to take beneficiary's case records from the ADHC center.

Review by State and Federal Agencies

Providers must make all administrative, personnel, and beneficiary records available to LDH or its designee and appropriate state and federal personnel within the specified timeframe given by LDH or its designee. Providers must always safeguard the confidentiality of beneficiary information.

Beneficiary Records

Providers must have a separate written record for each beneficiary served by the provider. For the purposes of continuity of care/support and for adequate monitoring of progress toward outcomes and services received, support coordination agencies and service providers must have on-going adequate chronological documentation of services offered and provided to beneficiaries they serve.

See tables below for specific information regarding documentation of services.

SUPPORT COORDINATION/TRANSITION INTENSIVE SUPPORT COORDINATION SERVICES	
Monthly Contacts	Complete each calendar month at the time of the monthly monitoring contact, according to the Office of Aging and Adult Services (OAAS) documentation and data entry requirements.
Interim Contacts	Complete at the time of interim activities, according to OAAS documentation and data entry requirements.
Quarterly Contacts	Complete each calendar quarter at the time of the quarterly monitoring contact, according to OAAS documentation and data entry requirements.
Annual Contacts	Complete in the last month of the POC year at the time of the annual monitoring contact, according to OAAS documentation and data entry requirements. **NOTE: The annual monitoring may be performed at the same time as the monthly monitoring or at another time during the last month of the POC year.**
Case Closure/Transfer	Complete within 14 calendar days of discharge.

TRANSITION SERVICES	
Receipts/Cancelled Checks	Document deposits, set-up fees, or items purchased and reimbursement made to purchaser(s) if outside of support coordination agency.
Transition Services Form (TSF)	Complete to obtain applicable approval for prior authorization.

ADULT DAY HEALTH CARE SERVICES	
Attendance Log	Complete daily with date and time of arrival and date and time of departure. **NOTE: An EVV system generated report satisfies this requirement.**
Progress Notes	Complete at least weekly and when there is a change in the beneficiary's condition or routine.
Progress Summary	Complete at least every 90 calendar days.
Case Closure/Transfer	Complete within 14 calendar days of discharge.

Organization of Records, Record Entries and Corrections

The organization of individual beneficiary records and location of documents within the record must be consistent among all records. Records must be appropriately thinned so that current material can be easily located in the record.

All entries and forms completed by staff in beneficiary records must be legible, written in ink and include the following:

1. The name of the person making the entry;
2. The signature of the person making the entry;
3. The functional title of the person making the entry;
4. The full date of documentation; and

5. Reviewed by the supervisor, if required.

Any error made by the staff in a beneficiary's record must be corrected using the legal method which is to draw a line through the incorrect information, write "error" by it and initial the correction. **Correction fluid must NEVER be used in a beneficiary's records.**

Progress Notes and Summaries

Progress notes document the daily delivery of services, activities, and observations, and it records the progress made toward meeting service goals in the beneficiary's Individualized Service Plan (ISP) and plan of care (POC).

Progress summaries are completed every 90 calendar days and provide an overview which addresses significant activities, progress toward the beneficiary's desired personal outcomes, and any changes in the beneficiary's status and service needs.

Progress notes must:

1. Document delivery of services identified on the POC and the ISP, as applicable;

2. Record activities and actions taken (by whom, where, etc.);

3. Provide adequate descriptions of activities and cannot be so general that a complete picture of the services and progress cannot be easily determined from the content of the note;

NOTE: General statements, such as "called the beneficiary"; "supported beneficiary"; or "assisted beneficiary", do NOT provide enough detail and are NOT sufficient. Check lists alone are NOT adequate documentation.

4. Record the progress (or lack of progress) being made and indicate whether the approaches in the POC and ISP are working;

5. Record any changes in the beneficiary's medical condition, behavior or home situation that may indicate a need for a re-assessment and POC and ISP change, if applicable;

NOTE: If there is a change in the beneficiary's condition or their normal routine, this must be recorded on the day of the actual occurrence.

6. Document the completion of incident reports, when appropriate;

7. Document any significant deviation from the POC and/or ISP, Examples include but are not limited to the following:

    a. Provided more assistance than what is indicated in the POC/ISP due to the beneficiary's request or increased need;

    b. Assistance not provided with a particular task/subtask as indicated in the POC/ISP due to beneficiary's request or lack of need; and

    c. Significant deviation from the POC's flexible scheduled arrival/departure time.

NOTE: Arriving or departing within a reasonable amount of time (e.g. 15 minutes of the flexible schedule's time) due to everyday factors such as traffic, etc. is NOT considered a significant deviation from the POC, AS LONG AS services are still provided at the same amount, frequency and duration, as indicated in the POC.

8. Be signed by the person providing the services.

Progress summaries must:

1. Take into account all of the progress notes and document significant trends, progress/lack of progress towards the personal outcomes and changes that may have impacted the POC and/or ISP and the needs of the beneficiary;
2. Include recommendations for any modifications to the POC and/or ISP as necessary; and
3. Be completed and updated by the supervisor (if applicable).

BOTH progress notes and progress summaries must:

1. Be in narrative format;

2. Be legible (including signature) and include the functional title of the person making the entry and date; and

3. Be entered in the beneficiary's record when a case is transferred or closed.

Discharge Summary for Transfers and Closures

In accordance with Medicaid licensing requirements, the ADHC center must provide a summary of the beneficiary's health record prior to the transfer/closure to the person or agency responsible for the future planning and care of the beneficiary. The ADHC center must also include any other information, including a progress summary, which would enable the receiving ADHC center/caregivers to provide the continued necessary care.

REIMBURSEMENT

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

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

Support Coordination

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

Transition Intensive Support Coordination (TISC)

The TISC is reimbursed at an established monthly rate (see to Appendix C – Billing Codes), for a maximum of six months (not to exceed 180 calendar days) from the POC approval date so long as the participant is residing in the nursing facility. Payment will not be authorized until the data contractor receives an approved POC indicating that the individual was/is a nursing facility resident during the time period in which prior authorization is requested.

Transition Services

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

The support coordination agency is then notified of the release of the authorization and can bill the

Medicaid fiscal intermediary for these expenses. If the support coordination agency did not initially pay for the pre-approved transition expenses, the support coordination agency shall reimburse the actual purchaser within ten calendar days of receipt of reimbursement.

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

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

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

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

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

ADHC Services

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

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

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

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

Span Date Billing

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

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

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

ADHC Provider Cost Reporting

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

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

The annual cost reports are the basis for determining reimbursement rates. A copy of all reports and statistical data must be retained by the center for no less than six (6) years following the date reports are submitted to the BHSF or its designee. A chart of accounts and an accounting system on accrual basis, or converted to the accrual basis at year's end, are required in the cost report preparation process. BHSF or its designee will perform desk reviews or audits of the cost reports. A representative number of the centers shall be subject to a full-scope, annual on-site audit. All ADHC cost reports must be filed based on a fiscal year from July 1 through June 30 and filed on or before the last day of September following the close of the cost reporting period.

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

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

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

ADHC Provider Audits

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

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

1. Withhold vendor payments until the center submits documentation that the non-compliance has been resolved;

2. Exclude the provider's cost from the database used for rate setting purposes; and

3. Impose civil monetary penalties until the center submits documentation that confirms the non-compliance has been resolved.

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

Vendor payments may also be withheld under the following conditions:

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

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

The ADHC provider must cooperate with the audit process by:

1. Promptly providing all documents needed for review;

2. Providing adequate space for uninterrupted review of records;

3. Making persons responsible for center records and cost report preparation available

during the audit;

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

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

6. Developing a plan of correction for areas of non-compliance with state and federal regulations immediately after the exit conference time limit of 30 calendar days.

ADHC Rate Determination

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

1. Direct care;

2. Care related costs;

3. Administrative and operating costs;

4. Property/capital costs; and

5. Transportation costs.

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

Exclusions from the ADHC Rate Determination Database

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

1. Providers with disclaimed audits; and

2. Providers with cost reports other than a 12-month period.

PROGRAM OVERSIGHT AND REVIEW

Services offered through the Adult Day Health Care (ADHC) Waiver are closely monitored to assure compliance with Medicaid's policy as well as applicable state and federal rules and regulations. Oversight is conducted through licensure compliance and program monitoring. The Louisiana Department of Health's (LDH) Health Standards Section (HSS) staff conduct on-site reviews to assure state licensure compliance for the providers they license. The Office of Aging and Adult Services (OAAS) staff conduct reviews to monitor compliance with Medicaid policy, waiver participation requirements, and the presence of personal outcomes as defined by beneficiaries served.

The OAAS regional office staff conduct on-site reviews of support coordination agencies. Details about the support coordination monitoring process are provided to support coordination agencies at the time of enrollment.

Health Standards Section Reviews

HSS reviews include an examination of administrative records, personnel records, and a sample of beneficiary records. In addition, ADHC providers are monitored with respect to the following:

1. Beneficiary access to needed services identified in the Plan of Care (POC) and Individualized Service Plan (ISP);

2. Quality of assessment and service planning;

3. Appropriateness of services provided including content, intensity, frequency and beneficiary input and satisfaction; and

4. Internal quality improvement.

A provider's failure to follow state licensing standards could result in the provider's removal from Medicaid participation, federal investigation, and prosecution in suspected cases of fraud.

On-Site Reviews

HSS on-site review with a provider is unannounced to ensure licensure compliance. The on-site review is comprised of the following:

1. Administrative Review;

2. Personnel Record Review;

3. Interviews; and

4. Beneficiary Record Reviews.

Administrative Review

The Administrative Review includes the following:

1. A review of administrative records;

2. A review of other agency documentation; and

3. Provider staff interviews as well as interviews with beneficiaries sampled to determine continued compliance with provider participation requirements.

Failure to respond promptly and appropriately to the HSS monitoring questions or findings may result in sanctions or liquidated damages and/or recoupment of payment.

Personnel Record Review

The personnel record review includes the following:

1. A review of personnel files;

2. A review of time sheets;

3. A review of the current organizational chart; and

4. Provider staff interviews to ensure that direct care staff and all supervisors meet the following staff qualifications:

    a. Education;

    b. Experience;

    c. Skills;

    d. Knowledge;

    e. Employment status;

    f. Hours worked;

g. Staff coverage;

h. Supervision documentation; and

i. Other applicable requirements.

Interviews

As part of the on-site review, the HSS staff will interview the following:

1. A representative sample of the individuals served by each provider employee;

2. Members of the beneficiary's network of support, which may include family and friends;

3. Direct care staff; and

4. Other members of the beneficiary's community. This may include support coordinators, support coordinator supervisors, other employees of the support coordination agency, direct service providers and other employees of the ADHC center.

This interview process is to assess the overall satisfaction of beneficiaries regarding the provider's performance, and to determine the presence of the personal outcomes defined and prioritized by the beneficiary/legal guardian.

Beneficiary Record Review

Following the interviews, the HSS staff may review the case records of a representative sample of beneficiaries served. The records will be reviewed to ensure that the activities of the provider are associated with the appropriate services of intake, ongoing assessment, care planning, and transition/closure.

Recorded documentation is reviewed to ensure that the services reimbursed were:

1. Identified in the POC and ISP (if applicable);

2. Provided to the beneficiary;

3. Documented properly; and

4. Are appropriate in terms of frequency and intensity.

The HSS staff will review the intake documentation of the ADHC Waiver beneficiary's eligibility and procedural safeguards, support coordination and professional assessments/reassessment documentation, service plans, service logs, progress notes and other pertinent information in the beneficiary record.

Report of Review Findings

Upon completion of the on-site review, the HSS staff discusses the preliminary findings of the review in an exit interview with appropriate staff of the ADHC provider. The HSS staff compiles and analyzes all data collected in the review, and a written report summarizing the monitoring findings and recommended corrective action is sent to the provider.

The review report includes the following:

1. Identifying information;

2. A statement of compliance with all applicable regulations; or

3. Deficiencies requiring corrective action by the ADHC provider.

The HSS program managers will review the reports and assess any sanctions as appropriate.

Corrective Action Report

The provider is required to submit a plan of correction to HSS within ten (10) working days of receipt of the report.

The plan must address how each cited deficiency has been corrected and how recurrences will be prevented. The provider is afforded an opportunity to discuss or challenge the HSS monitoring findings.

Upon receipt of the written Plan of Correction, HSS program managers review the provider's plan to assure that all findings of deficiency have been adequately addressed. If all deficiencies have not been addressed, the HSS program manager responds to the provider and requests immediate resolution of the deficiencies in question.

A follow-up review will be conducted when deficiencies have been found to ensure that the provider has fully implemented the plan of correction. Follow-up reviews may be conducted on-site or via evidence review.

Informal Dispute Resolution (Optional)

In the course of the review process, providers may request an informal hearing with HSS staff. The provider is notified of the right to an informal hearing in correspondence that details the cited deficiencies. The informal hearing is optional on the part of the provider and in no way limits the providers' rights to a formal appeal hearing. In order to request the informal hearing, the provider should contact the program manager at HSS. (See Appendix A for contact information).

This request must be made within the time limit given for the corrective action recommended by HSS.

The provider is notified of time and place where the informal hearing will be held. The provider should bring all supporting documentation that is to be submitted for consideration. Every effort will be made to schedule a hearing at the convenience of the provider.

The HSS program manager convenes the informal hearing and will conduct the hearing in a non-formal atmosphere. The provider is given the opportunity to present its case and to explain its disagreement with the monitoring findings. The provider representatives are advised of the date that a written response will be sent and are reminded of its right to a formal appeal.

There is no appeal of the informal hearing decision; however, the provider may appeal the original findings to the Division of Administrative Law.

Fraud and Abuse

When HSS staff detects patterns of abusive or fraudulent Medicaid billing, the provider will be referred to the Program Integrity Section for investigation and sanctions, if necessary. Investigations, recoupments and sanctions may also be initiated from reviews conducted by the Surveillance and Utilization Review System (SURS) and/or Program Integrity Section. LDH has an agreement with the Attorney General's Office which provides for the Attorney General's office to investigate Medicaid fraud. The Office of the Inspector General, Federal Bureau of Investigation (FBI), and the Centers for Medicare and Medicaid Services (CMS) also conduct investigations of Medicaid fraud.

Support Coordination Monitoring

The OAAS regional staff conducts annual monitoring of each support coordination agency as a means of monitoring compliance with Medicaid policy, waiver participation requirements, and the presence of personal outcomes as defined by beneficiaries served. The results of the monitoring process are reported to the support coordination agency along with any required follow-up actions and timelines. Recurrent problems are to be addressed by the support coordination agency through

systemic changes resulting in improvements. Support coordination agencies who do not perform all of the required follow-up actions according to the specified timelines are subject to sanctions.

Support coordination agencies are responsible for the following in the monitoring process:

1. Offering full cooperation with OAAS;
2. Providing policy and procedure manuals, personnel records, case records, and other documentation, as requested;
3. Providing space for documentation review and support coordinator interviews;
4. Coordinating with agency support coordinator interviews; and
5. Assisting with scheduling beneficiary interviews.

Providers may refer to Appendix B of this manual chapter for further information regarding the support coordination monitoring process.

INCIDENTS, ACCIDENTS AND COMPLAINTS

Support coordinators and adult day health care (ADHC) providers are responsible for reasonably ensuring the health and welfare of the beneficiary and are required to report all incidents, accidents, or suspected cases of abuse, neglect, exploitation or extortion. Reporting shall be in accordance with applicable laws, rules and policies and be made to the appropriate agency named below. Reporting only to a supervisor does not satisfy the legal requirement to report. The supervisor must be responsible for ensuring that reports or referrals are made in a timely manner to the appropriate agency.

Incident/Accident Reports

Providers are responsible for documenting and maintaining records of **all incidents and accidents** involving the beneficiary. A report of the incident/accident must be maintained in a central records system. The report shall include, at a minimum, the following:

1. Beneficiary identifying information;
2. Event information (including date, time, location, etc.) of the incident/accident;
3. Circumstances surrounding the incident/accident;
4. Description of the incident/accident (including any medical attention or law enforcement involvement, witnesses, etc.);
5. Description of action taken by the ADHC center and recommendations to prevent future occurrences; and
6. Name of person completing the report.

Critical Incident Reports

Additional provider responsibilities apply to incidents defined as critical. Critical incidents include, but are not limited to, those involving the following:

1. Abuse;
2. Neglect;
3. Exploitation;
4. Extortion;

5. Major injury;
6. Major medical events;
7. Death;
8. Major behavioral incidents;
9. Involvement with law enforcement;
10. Loss or destruction of a beneficiary's home;
11. Falls; and
12. Major medication incidents.

Critical incidents are fully defined in the Office of Aging and Adult Services' (OAAS) *Critical Incident Reporting Policy and Procedures* and include the specific provider responsibilities that must be followed. Non-compliance will result in administrative actions. (See Appendix B for information on obtaining this policy).

Imminent Danger and Serious Harm

Providers shall report all suspected cases of abuse (physical, mental, emotional and/or sexual), neglect, exploitation or extortion to the appropriate authorities. In addition, any other circumstances that place the beneficiary's health and welfare at risk should be reported to the appropriate authorities. (See Appendix A for contact information).

For beneficiaries ages 18 through 59 and emancipated minors, Adult Protective Services (APS) must be contacted. An APS staff investigates and arranges for services to protect adults with disabilities at risk of abuse, neglect, exploitation or extortion. (See Appendix A for contact information).

For beneficiaries ages 60 or older, Elderly Protective Services (EPS) must be contacted. EPS investigates situations of abuse, neglect and/or exploitation of individuals age 60 or older. (See Appendix A for contact information).

If the beneficiary needs emergency assistance, the worker must call 911 or the local law enforcement agency before contacting the supervisor.

The responsibilities of the support coordination agency and the direct service provider (ADHC provider) are outlined in the *OAAS Critical Incident Reporting Policy and Procedures*. (See Appendix B for information on obtaining this policy).

Internal Complaint Policy

Beneficiaries must be able to file a complaint regarding their services without fear of reprisal. The support coordination agency and ADHC provider must have a written policy to handle beneficiary complaints. In order to ensure that the complaints are efficiently handled, the agency/provider must comply with the following procedures:

1. Designate an employee to act as a complaint coordinator to investigate complaints. The complaint coordinator must maintain a log of all complaints received. The complaint log must include the date the complaint was made, the name and telephone number of the complainant, nature of the complaint and resolution of the complaint;

2. Forward all written complaints to the complaint coordinator. If the complaint is verbal, the staff member receiving the complaint must document all pertinent information in writing and forward it to the complaint coordinator;

3. The complaint coordinator must send a letter to the complainant acknowledging receipt of the complaint **within five (5) working days**;

4. The complaint coordinator must thoroughly investigate each complaint. The investigation includes, but is not limited to, gathering pertinent facts from the beneficiary, the responsible representative, the employee, and other interested parties. The agency/provider is encouraged to use all available resources to resolve the complaint internally. The employee's supervisor must be informed of the complaint and the resolution; and

5. The agency/provider must inform the beneficiary, the complainant, and/or the responsible representative in writing **within ten (10) working days** of receipt of the complaint and the results of the internal investigation.

If the beneficiary is dissatisfied with the results of the provider's internal investigation, they may continue the complaint resolution process by contacting Health Standards Section (HSS). (See Appendix A for contact information).

If the beneficiary is dissatisfied with the results of the support coordination agency's internal investigation, they may continue the complaint resolution process by contacting the OAAS regional office. (See Appendix A for contact information).

SUPPORT COORDINATION

Support coordination, also referred to as case management, is an organized system by which a support coordinator assists a beneficiary to prioritize and define their personal outcomes and to identify, access, coordinate and monitor appropriate supports and services within a community service network. Beneficiaries may have multiple service needs and require a variety of community resources.

Core Elements

Support coordination agencies are required to perform the following:

1. Intake;
2. Assessment/reassessment:
    a. Evaluation/re-evaluation of level of care (LOC) and need for waiver services.
3. Plan of care (POC) development and revision of POC:
    a. Linkage to direct services and other resources; and
    b. Coordination of multiple services among multiple providers.
4. Follow-Up/monitoring:
    a. On-going assessment and mitigation of health, behavioral and personal safety risk; and
    b. Responding to beneficiary crisis.
5. Critical incident management; and
6. Transition/discharge and closure.

For additional details on support coordination responsibilities, procedures, and timelines, refer to Appendix B for the hyperlink to the *Office of Adult and Aging Services (OAAS) Waiver Procedures Manual.*

Other Support Coordination Responsibilities

The support coordinator is responsible for managing the beneficiary's Adult Day Health Care (ADHC) Waiver services and long-term personal care services (LT-PCS), if applicable, in a way that does not duplicate services when the beneficiary is also receiving other services, such as home health or hospice services.

Support coordinators are also responsible for reporting critical incidents. For additional details regarding reporting requirements, procedures and timelines, refer to Appendix B for the hyperlink to the *Critical Incident Reporting* website.

CONTACT INFORMATION

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
OAAS State Office	Provides waiver assistance, clarification of waiver services, receives complaints regarding waiver services	Office of Aging and Adult Services P. O. Box 2031, Bin #14 Baton Rouge, LA 70821-2031 1-866-758-5035
OAAS Regional Offices	Reviews and provides approval of waiver services, monitors support coordination services and offers providers technical assistance	http://ldh.la.gov/index.cfm/directory/category/141
Gainwell Provider Enrollment Unit	Office to contact to report changes in agency ownership, address, telephone number or account information affection electronic funds transfer	Gainwell Provider Enrollment Unit P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370 or (225) 924-5040 http://www.lamedicaid.com/provweb1/Provider_Enrollment/ProviderEnrollmentIndex.htm
Gainwell Provider Relations Unit	Office to contact to obtain assistance with questions regarding billing information and billing issues	Gainwell Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783 or (225) 924-5040 http://www.lamedicaid.com/provweb1/Provider_Support/provider_supportindex.htm
Statistical Resources, Inc.	Agency to contact regarding CMIS, LaSRS, EVV, and PA Billing Issues	11505 Perkins Road Suite #H Baton Rouge, LA 70810 (225) 767-0501

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
LDH- Health Standards Section	Office to contact to report changes that affect provider license (e.g. Address Change, Change of Ownership, etc.) Office to contact when providers wish to request an informal hearing as the result of provider's receipt of a statement of deficient practice or file a complaint against a provider by a beneficiary	Health Standards Section P.O. Box 3767 Baton Rouge, LA 70821 1-800-660-0488
Division of Administrative Law- LDH Section	Office to contact to request an appeal hearing	Division of Administrative Law 1020 Florida Street Post Office Box 44033 Baton Rouge, LA 70802 Phone: (225) 342-1800 Fax: (225) 342-1813 https://www.adminlaw.state.la.us/
Medicaid Program Integrity	Office to contact to report Medicaid fraud	Provider Fraud Hotline# 1-800-488-2917 Beneficiary Fraud Hotline# 1-888-342-6207 Provider Fraud Fax: (225) 216-6129 Beneficiary Fraud Fax: (225) 389-2610 http://ldh.la.gov/index.cfm/page/219

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
Adult Protective Services	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of adults ages 18-59 and emancipated minors	1-800-898-4910
Elderly Protective Services	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion involving adults age 60 and older	1-833-577-6532
Myers and Stauffer LC	Information about filing cost reports and templates	http://www.mslc.com/Louisiana/HCBS.aspx
Adult Day Health Care Resources	Resources containing provider training and/or cost report training	http://ldh.la.gov/index.cfm/newsroom/detail/1573
Healthy Louisiana (Medicaid Managed Care Organizations)	Healthy Louisiana (previously called Bayou Health) is the way most of Louisiana's Medicaid and LaCHIP beneficiaries receive health care services. In Healthy Louisiana, Medicaid beneficiaries enroll in a Health Plan	http://ldh.la.gov/index.cfm/subhome/6

FORMS/LINKS

The following documents, forms, links, and manuals are available on the following website addresses:

Form/Document/Website Name	Website Address
Rights and Responsibilities for Applicants/Participants of Home and Community Based Services (HCBS) Waivers	http://ldh.la.gov/assets/docs/OAAS/publications/RightsRespon_Waivers.pdf
Transition Services Form (TSF)	http://ldh.la.gov/assets/docs/OAAS/CCWForms/Transition-Services-Form.pdf
Emergency Plan	http://ldh.la.gov/assets/docs/OAAS/EmergencyPrep/EmergencyPlanandAgreementForm.pdf
Electronic Visit Verification (EVV)	http://ldh.la.gov/index.cfm/page/2751
OAAS Critical Incident Reporting Webpage	http://www.ldh.la.gov/index.cfm/newsroom/detail/1418?uuid=1295548571800
Request for Payment/Override Form	http://ldh.la.gov/assets/docs/OAAS/publications/Forms/Request-for-Payment-Override-Form.pdf
Support Coordination Monitoring Policy and Procedures Manual	http://www.ldh.la.gov/assets/docs/OAAS/Manuals/Support-Coordination-Monitoring-Policy-Procedures.pdf
Waiver Procedures Manual	http://ldh.louisiana.gov/index.cfm/newsroom/detail/2923
Support Coordination Transfer of Records Form	http://www.ldh.la.gov/assets/docs/OAAS/CCWForms/Support-Coordination-Transfer-of-Records-Form.pdf
Louisiana State Adverse Actions List Search and Office of the Inspector General	https://adverseactions.ldh.la.gov/SelSearch https://exclusions.oig.hhs.gov/

Form/Document/Website Name	Website Address
Federal System Award Management	https://www.sam.gov/SAM/pages/public/searchRecords/search.jsf
Medicaid Services Chart	http://ldh.la.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf

BILLING CODES

Information on procedure codes and the current rates is available at:
https://www.lamedicaid.com/provweb1/fee_schedules/ADHC_Billing_Codes_Current.pdf

GLOSSARY

This is a list of abbreviations, acronyms, and definitions used in the Adult Day Health Care (ADHC) Waiver Manual Chapter.

Abuse –The infliction of physical or mental injury, or actions which may reasonably be expected to inflict physical injury, on a beneficiary by other parties, including but not limited to such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds or other things of value. (La. R.S. 15:1503)

Abuse of Medicaid Funds – Inappropriate use of public funds by either providers or beneficiaries, including practices which are not criminal acts and which may even be technically legal, but which still represent the inappropriate use of public funds.

Activities of Daily Living (ADLs) − The functions or basic self-care tasks which an individual performs in a typical day, either independently or with supervision/assistance. Activities of daily living include bathing, dressing, eating, grooming, walking, transferring and/or toileting. The extent to which a person requires assistance to perform one or more of these activities often is a level of care criterion.

ADHC – A medical model ADHC program designed to provide services for medical, nursing, social, and personal care needs to adults who have physical, mental or functional impairments. Such services are rendered by utilizing licensed professionals in a community based direct care center.

Adult Day Health Care Center – Any place owned or operated for profit or nonprofit by a person, society, agency, corporation, institution, or any group wherein two or more adults with functional impairments who are not related to the owner or operator of such agency are provided with adult day health care services. This center type will be open and providing services at least five continuous hours in a 24-hour day for at least five days a week.

ADHC Waiver – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to individuals who: are age 65 or older, or aged 22-64 and have a physical disability, and meet nursing facility level of care requirements.

Advocacy –The process of assuring that beneficiaries receive appropriate high quality supports and services and locating additional services needed by beneficiaries which are not readily available in the community.

Agency – An entity which delivers Medicaid support coordination services under an agreement

with LDH/OAAS.

Allegation of non-compliance – A claim that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a beneficiary or beneficiaries. (La. R.S. 40:2009.14)

Allowable Cost – Those expenses 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.

Appeal – A request for a fair hearing concerning a proposed agency action, a completed agency action, or failure of the agency to make a timely determination. A legal proceeding in which the applicant/enrollee and OAAS representative, or designee, presents the case being appealed in front of an impartial hearing officer. (See Fair Hearing).

Applicant – An individual who is requesting Medicaid Waiver services.

Assessment – One or more processes that are used to obtain information about an individual, including their condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that an individual meets nursing facility level of care and requires waiver services. The results are used to develop the Plan of Care (POC) and an Individualized Service Plan.

Beneficiary – An individual who has been certified for Adult Day Health Care through a Medicaid Waiver program. A beneficiary may also be referred to as a participant.

Bureau of Health Services Financing (BHSF) – The Bureau within the Louisiana Department of Health is responsible for the administration of the Medicaid program and is the administering agency for the OAAS Waiver programs.

Case Management – (See Support Coordination).

Centers for Medicare and Medicaid Services (CMS) – The agency in the Department of Health and Human Services (DHHS) responsible for federal administration of the Medicaid and Medicare programs.

Community Choices Waiver – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to individuals who: are age 65 or older, or aged 21-64 and have a physical disability, and meet nursing facility level of care requirements.

Complaint – An allegation that an event has occurred or is occurring and has the potential for causing more than minimal harm to a beneficiary. (La. R.S. 40:2009.14).

Continuous Quality Improvement – An ongoing process to objectively and systematically monitor and evaluate the quality of services provided to individuals served by Medicaid, to pursue opportunities to improve services, and to correct identified problems.

Confidentiality – The process of protecting a beneficiary's or an employee's personal information as required by the Health Insurance Portability and Accountability Act (HIPAA).

Corrective Action Plan – Written description of action a provider plans to take to correct identified deficiencies.

Department of Health and Human Services (DHHS) – The federal agency responsible for administering the Medicaid Program and public health programs.

Direct Care Staff – Unlicensed staff paid to provide personal care or other direct service and support to qualified waiver beneficiary's to enhance their well-being, and who are involved in face-to-face direct contact with the participant.

Electronic Visit Verification (EVV) – A web-based system that electronically records and documents the precise date, start and end times that services are provided to beneficiaries. The EVV system will ensure that beneficiaries are receiving services authorized in their POCs, reduce inappropriate billing/payment, safeguard against fraud and improve program oversight.

Eligibility – The determination of whether or not a beneficiary qualifies to receive waiver services based on meeting established criteria as set by LDH.

Enrollment – A determination made by LDH that a provider or agency meets the necessary requirements to participate as a Medicaid provider. This is also referred to as provider enrollment.

Exploitation – The illegal or improper use or management of the funds, assets, or property of a person who is aged or an adult with a disability, or the use of power of attorney or guardianship of a person who is aged or an adult with a disability for one's own profit or advantage. (La. R.S. 15:1503)

Extortion – The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority. (La. R.S. 15:1503)

Fair Hearing – A legal proceeding in which the beneficiary and OAAS representative, or designee, presents the case being appealed in front of an impartial hearing officer.

Fiscal Intermediary – The contractor, managed by Medicaid, which processes claims, issues payments to providers and agencies, handles provider inquiries and complaints, provides training for providers.

Follow-Up – A core element of service delivery to the beneficiary that includes oversight and monitoring of the provision of services, ongoing assessment and mitigation of health, behavioral and personal safety risk, and crisis management.

Formal Services – Another term for professional and paid services.

Good Cause – An acceptable reason to change agencies or providers outside of the designated circumstances and timelines.

Health Standards Section (HSS) – A section of the Louisiana Department of Health responsible for the licensure and enforcement of compliance of those health care providers licensed by the Health Standards Section.

Home and Community-Based Services Waiver – An optional Medicaid program established under 1915(c) of the Social Security Act designed to provide services in the beneficiary's home or community as an alternative to institutional services to individuals who meet nursing facility level of care. Waiver services are approved by CMS and are limited to serving a specific number of individuals in accordance with the approved and available waiver opportunities.

Individualized Service Plan (ISP) – An individualized written plan of action to be completed and followed by the ADHC center to address the beneficiary's difficulties, health care needs, and services based upon their assessment.

Informal Services – Another term for non-professional or non-paid services provided by family, friends and community/social network.

Institutionalization – Placement of a beneficiary in any inpatient facility including, but not limited to a hospital, nursing facility, or psychiatric hospital.

Legal Guardian – A person who has been granted custody of an individual by a court order.

Licensed Practical Nurse (LPN) – an individual currently licensed by the Louisiana State Board of Practical Nurse Examiners to practice practical nursing in Louisiana. The LPN works under the supervision of a registered nurse.

Licensure – A determination by the Health Standards Section that a provider meets the requirements of State law to provide health care and services.

Linkage – Act of connecting a beneficiary to a specific support coordination agency or a provider.

Long Term-Personal Care Services (LT-PCS) – A Medicaid state plan service which provides assistance with ADL and IADL as an alternative to institutional care to qualified Medicaid beneficiaries who are age 21 or older and meet specific program requirements.

Louisiana Department of Health (LDH) - The state agency responsible for administering the state's Medicaid Program and other health and related services including aging and adult services, public health, mental health, developmental disabilities, and behavioral health services.

Medicaid – A federal-state financed medical assistance program that is provided under a State Plan approved under Title XIX of the Social Security Act.

Medicaid Fraud – An act of any person with the intent to defraud the state through any medical assistance program created under the federal Social Security Act and administered by LDH or any other state agency. (LA RS 14:70.1)

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system for the Medicaid Program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible beneficiaries.

Medicare – The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

Minimal Harm – An incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the beneficiary's activities of daily living. (La. R.S. 40:2009.14)

Neglect – The failure by a care giver responsible for an adult's care or by other parties to provide the proper or necessary support or medical, surgical, or any other care necessary for their well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (La. R.S. 15:1503)

Non-allowable costs – Costs that are not based on the reasonable cost of services covered under Medicare/Medicaid and are not related to the care of beneficiaries.

Nursing Facility (NF) – A facility which meets the requirements of sections 1819 or 1919 (a) (b) (c) and (d) of the Social Security Act. A nursing facility provides intermediate, skilled nursing, and/or long term care for those individuals who meet the eligibility requirements.

Office of Aging and Adult Services (OAAS) – The office within LDH that is responsible for the management and oversight of certain Medicaid home and community-based services waiver programs, state plan programs, adult protective services for adults ages 18 through 59, and other programs that offer services and supports to the elderly and adults with disabilities.

OAAS Regional Office – One of nine administrative offices within the Office of Aging and Adult Services.

Office of Behavioral Health (OBH) – The office in LDH that is responsible for services to individuals with behavioral or addictive disorders.

Office of Public Health (**OPH**) – The office in LDH responsible for personal and environmental health services.

Office for Citizens with Developmental Disabilities (OCDD) – The office in LDH responsible for services to individuals with developmental disabilities.

Personal Outcome – Result achieved by or for the waiver beneficiary through the provision of services and supports that make a meaningful difference in the quality of the beneficiary's life.

Person-Centered – An approach used in the assessment and planning processes that considers a beneficiary's personal experiences and preferences.

Plan of Care (POC) – A written person-centered plan developed by the beneficiary, their responsible representative and support coordinator based on assessment results. The plan specifies services to be accessed and coordinated by the support coordinator on the beneficiary's behalf and includes long-range goals, assignment of responsibility, and time frames for completion or review by the support coordinator.

Program of All-Inclusive Care for the Elderly (PACE) – Program which coordinates and provides all needed preventive, primary health, acute and long-term care services to qualified beneficiaries age 55 and older in order to enhance their quality of life and allow them to continue to live in the community.

Progress Notes – Documentation of the delivery of services, activities and observations of a beneficiary to record progress toward the goals indicated in the POC and/or ISP.

Provider – An entity which delivers Medicaid services under a provider agreement with LDH.

Provider Agreement – A contract between the provider of services and the Medicaid program or other LDH office. The agreement specifies responsibilities with respect to the provision of services

and payment under Medicaid or other LDH office.

Provider Enrollment – See " Enrollment".

Re-assessment – See "Assessment". The re-assessment is completed at least annually for waiver beneficiaries and when a significant status change occurs in order to update the POC and/or ISP.

Registered Nurse (RN) – An individual currently licensed by the Louisiana State Board of Nursing to practice professional nursing in Louisiana.

Representative Payee – A person designated by the Social Security Administration to receive and disburse benefits in the best interest of and according to the needs of the Medicaid-eligible beneficiary.

Responsible Representative – An adult who has been designated by the beneficiary to act on their behalf with respect to their services. The written designation of a responsible representative does not give legal authority for that individual to independently handle the beneficiary's business without the beneficiary's involvement. In the case of an interdicted individual, the responsible party must be the curator appointed by the court of competent jurisdiction.

Request for Services Registry (RFSR) – A waiting list for the ADHC Waiver program which contains the names and dates of requests of individuals applying for an ADHC Waiver opportunity.

Self-neglect – The failure, either by the adult's action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected. (La. R.S. 15:1503)

Sexual abuse – Any non-consensual sexual activity between a beneficiary and another individual. Sexual activity includes, but is not limited to kissing, hugging, stroking, or fondling with sexual intent; oral sex or sexual intercourse; insertion of objects with sexual intent; request, suggestion, or encouragement by another person for the beneficiary to perform sex with any other person when beneficiary is not capable of or competent to refuse.

Support Coordination – Services provided to eligible beneficiaries to help them gain access to the full range of needed services including medical, social, educational, housing, and other support services regardless of the funding source for these services. Activities also include assessment, POC development, service monitoring, critical incident management, and transition/discharge.

Support Coordinator – An individual who meets the required qualifications and who is employed

by a Support Coordination Agency.

Transition – A shift from a beneficiary's current services to another appropriate level of services, including discharge from all services.

Waiver Opportunity – An offer made to an individual on the ADHC Waiver Request for Services Registry. Waiver opportunities are limited to a finite number of individuals each year as approved by the state legislature and CMS.

CLAIMS RELATED INFORMATION

Hard copy billing of waiver services is billed on the paper CMS-1500 (02/12) claim form or electronically on the 837P Professional transaction. Instructions in this appendix are for completing the CMS-1500; however, the same information is required when billing claims electronically. Items to be completed are listed as **required, situational** or **optional**.

Required information must be entered in order for the claim to be processed. Claims submitted with missing or invalid information in these fields will be returned unprocessed to the provider with a rejection letter listing the reason(s) the claims are being returned, or will be denied through the system. These claims cannot be processed until corrected and resubmitted by the provider.

Situational information may be required, but only in certain circumstances as detailed in the instructions that follow.

Paper claims should be submitted to:

Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

NOTE: Electronic claims submission is the preferred method for billing. (See the EDI Specifications located on the Louisiana Medicaid website at www.lamedicaid.com, directory link "HIPAA Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide).

This appendix includes the following:

1. Instructions for completing the CMS 1500 claim form and samples of completed CMS-1500 claim forms; and

2. Instructions for adjusting/voiding a claim and samples of adjusted CMS 1500 claim forms.

CMS 1500 (02/12) Instructions for Waiver Services

In order to access the CMS 1500 (02/12) Instructions for Waiver Services and to view sample forms, use the following link:
https://www.lamedicaid.com/Provweb1/billing_information/CMS_1500.htm.

NOTE: You must write "WAIVER" at the top center of the claim form.

ADJUSTING/VOIDING CLAIMS

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form.

Only a paid claim can be adjusted or voided. Denied claims must be corrected and resubmitted, not adjusted or voided.

Only one claim line can be adjusted or voided on each adjustment/void form.

For those claims where multiple services are billed and paid by service line, a separate adjustment/void form is required for each claim line if more than one claim line on a multiple line claim form must be adjusted or voided.

The provider should complete the information on the **adjustment** exactly as it appeared on the original claim, **changing only the item(s) that was in error and noting the reason for the change in the space provided on the claim**.

If a paid claim is being voided, the provider must enter all the information on the **void** from the original claim exactly as it appeared on the original claim. After a voided claim has appeared on the Remittance Advice, a corrected claim may be resubmitted (if applicable).

Only the paid claim's most recently approved internal control number (ICN) can be adjusted or voided; thus:

1. If the claim has been successfully adjusted previously, the most current ICN (the ICN of the adjustment) must be used to further adjust the claim or to void the claim; or

2. If the claim has been successfully voided previously, the claim must be resubmitted as an original claim. The ICN of the voided claim is no longer active in claims history.

If a paid claim must be adjusted, almost all data can be corrected through an adjustment with the exception of the Provider Identification Number and the Beneficiary/Patient Identification Number. **Claims paid to an incorrect provider number or for the wrong Medicaid beneficiary cannot be adjusted. They must be voided and corrected claims submitted.**

Adjustments/Voids Appearing on the Remittance Advice

When an Adjustment/Void Form has been processed, it will appear on the Remittance Advice under ***Adjustment or Voided Claim***. The adjustment or void will appear first. The original claim line will appear in the section directly beneath the Adjustment/Void section.

The approved adjustment will replace the approved original and will be listed under the "Adjustment" section on the RA. The original payment will be taken back on the same RA and appear in the "Previously Paid" column.

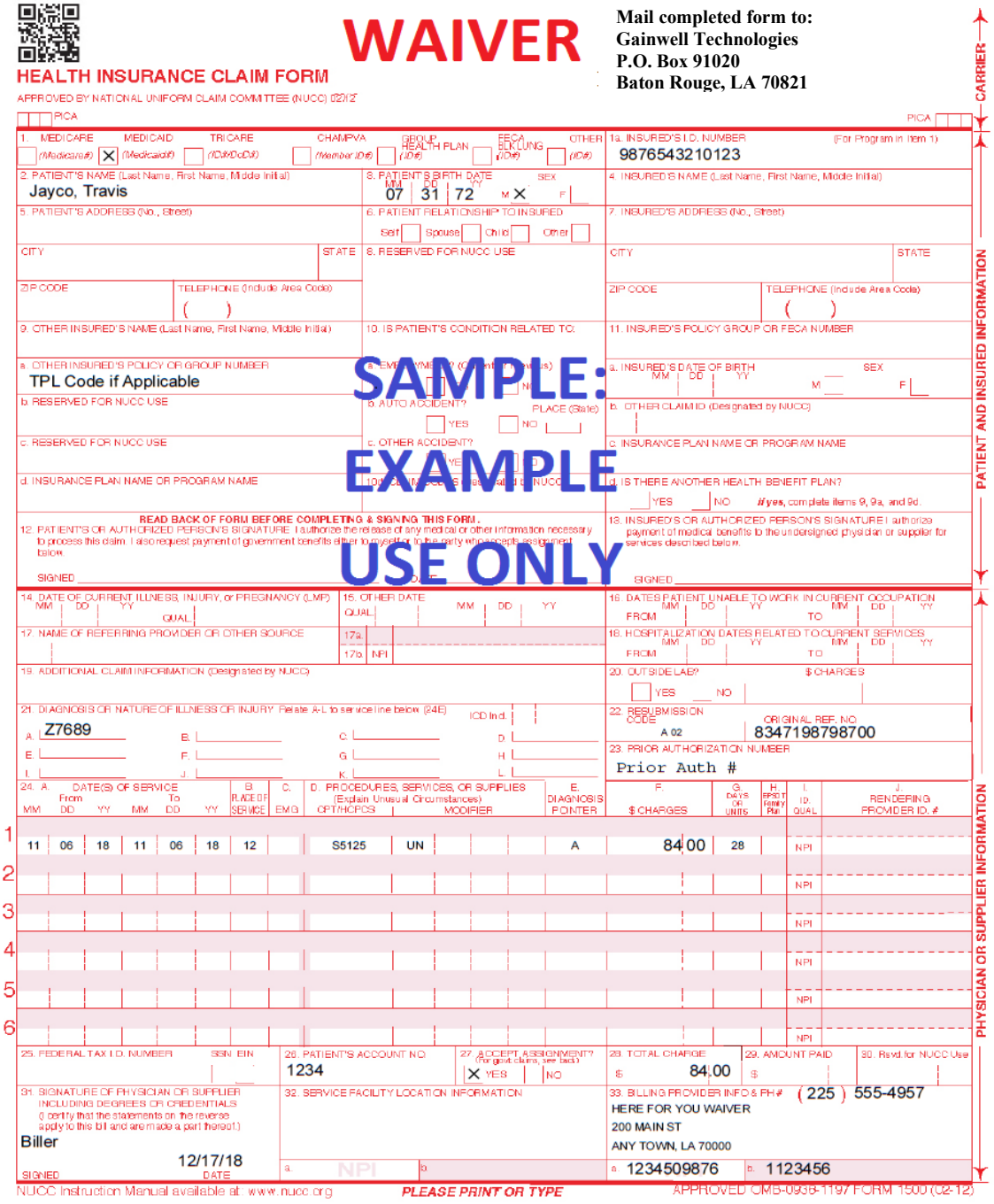
When the void claim is approved, it will be listed under the "Void" column of the RA.

An Adjustment/Void will generate Credit and Debit Entries which appear in the Remittance Summary on the last page of the Remittance Advice.

Providers should refer to the General Information and Administration Provider Manual chapter of the Medicaid Services Manual located on the Louisiana Medicaid website below for general information concerning topics relative to general claims filing. To access the General Information and Administration Provider Manual chapter, click here:
http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf.

Sample forms are on the following pages.

SAMPLE WAIVER CLAIM FORM ADJUSTMENT



WAIVER

Mail completed form to:
Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SAMPLE:
EXAMPLE
USE ONLY

1. MEDICARE (Medicare#) X | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1): 9876543210123
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jayco, Travis
3. PATIENT'S BIRTH DATE: 07 31 72 SEX: M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other
7. INSURED'S ADDRESS (No., Street)
CITY | STATE
8. RESERVED FOR NUCC USE
ZIP CODE | TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL Code if Applicable
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL
15. OTHER DATE QUAL MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. Z7689 B. C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE: A 02 ORIGINAL REF. NO.: 8347198798700
23. PRIOR AUTHORIZATION NUMBER: Prior Auth #

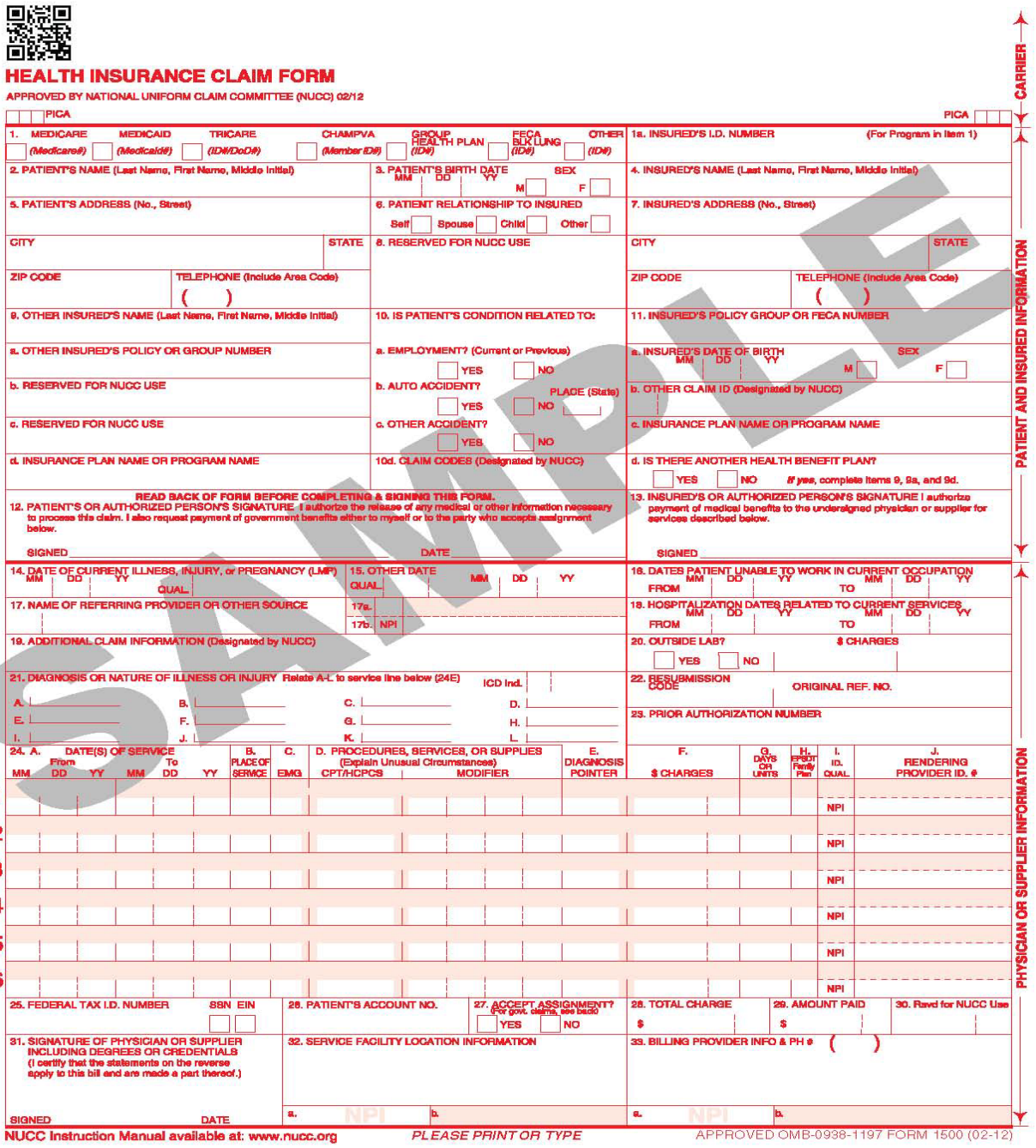
24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	11	06	18	11	06	18	12		S5125	UN		A	84 00	28		NPI	
2																NPI	
3																NPI	
4																NPI	
5																NPI	
6																NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.: 1234
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO
28. TOTAL CHARGE: $ 84.00
29. AMOUNT PAID $
30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Biller
SIGNED 12/17/18 DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH # (225) 555-4957
HERE FOR YOU WAIVER
200 MAIN ST
ANY TOWN, LA 70000
a. 1234509876 b. 1123456

NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE CLAIM FORM



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

CONCURRENT SERVICES

Waiver services that are available while a beneficiary is in a hospital or in a nursing facility are considered concurrent services. Some Adult Day Health Care (ADHC) Waiver services are payable when a beneficiary is in a hospital or nursing facility. All services must be prior approved as indicated in Section 9.1 – Covered Services.

The following ADHC Waiver services are payable when a beneficiary who has been receiving ADHC Waiver services has a temporary stay in a hospital or a nursing facility or when a beneficiary is transitioning from a nursing facility to the community:

Payable Waiver Services During a Temporary Stay in a Nursing Facility or Hospital
1. Support Coordination.

Payable Waiver Services When Transitioning from a Nursing Facility to the Community
1. Transition Intensive Support Coordination; and 2. Transition Services.

E. Periodic Time Studies.--Periodic time studies, in lieu of ongoing time reports, may be used to allocate direct salary and wage costs. However, the time studies used must meet the following criteria:

1. The time records to be maintained must be specified in a written plan submitted to the intermediary no later than 90 days prior to the end of the cost reporting period to which the plan is to apply. The intermediary must respond in writing to the plan within 60 days from the date of receipt of the request, whether approving, modifying, or denying the plan.

2. A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.

3. Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).

4. The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.

5. No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.

6. The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.

7. The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

The intermediary may require the use of different, or additional, weeks in the study in its response to the provider's request for approval and may prospectively require changes in the provider's request as applied to subsequent cost reporting periods.

2314. LIMITATION OF ALLOCATION OF INDIRECT COSTS WHERE ANCILLARY SERVICES ARE FURNISHED UNDER ARRANGEMENTS

A. "No Overhead Allocation" Method.--

1. Where a provider furnishes ancillary services to Medicare patients under arrangements with others, the provider must pay the supplier and request reimbursement from the Medicare program. Where a provider simply arranges for such services for non-Medicare patients, and does not pay the non-Medicare portion of such services, its books will reflect only the cost of the Medicare portion. Therefore, allocation of indirect costs to a cost center which includes only the cost of the Medicare portion would result in excessive assignment of indirect costs to the program. Since services were also arranged for non-Medicare patients, part of the overhead costs should be allocated to that group.

Consequently, in the foregoing situation, no indirect costs may be allocated to the Medicare portion. Instead, the total indirect costs will be allocated to all other departments so that each of these departments will absorb proportionately those indirect costs which otherwise would have been allocated to the arranged for services. In this way, Medicare will share in such indirect costs in the proportion that it shares in the costs of all other services furnished directly by the provider.

5

Jeff Landry
GOVERNOR

Michael Harrington, MBA, MA
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

M E M O R A N D U M

DATE: July 1, 2024

TO: Administrators of ADHC Centers

FROM: Lindsey Nizzo, Medicaid Program Manager

SUBJECT: Submission of FYE 6-30-2024 ADHC Cost Reports

This letter is to remind you that annual cost reports (center and central office, if applicable) must be submitted by **September 30, 2024.** These reports cover the period of July 1, 2023 through June 30, 2024.

Attached are the ADHC payment system rate calculations. The Direct Care Component amount for dates of service 7/1/2023 to 6/30/2024 was $2.08 per quarter hour increment. This amount will be needed to prepare the Direct Care cost settlement.

Please note the following updates:

1. Home Delivered Meals and ADHC Health Status Monitoring:

For FY24, Schedule B – Stats has been updated to include lines 8.d., 8.e. and 10 to report the ADHC Health Status Monitoring Units (ADHC HSM) and Home Delivered Meals (HDMs) which correspond to the revenues reported on Schedule G, Lines 2a and 2b. It is critical that these new lines on Schedule B be completed accurately on your as-filed cost report. Inaccurate reporting of ADHC HSM and HDM statistics on Schedule B will impact the amount that is owed by the provider to LDH for FY 2024.

Schedule H, Lines F1 and F2 have been removed from the FY24 cost report template, and providers should not attempt to differentiate the expenses related to these services at this time. These expenses should be reported alongside all other cost in the applicable A through E sections.

Schedule K has been modified to separately calculate the Direct Care Floor for the ADHC services and the Direct Care Floor for the ADHC HSM services (with the assumption from LDH that 10% of the $47.35 per diem rate is related to Direct Care). The actual cost for both services is then calculated and compared to the Total Direct Care Floor to determine if an amount is due to LDH.

2. Cost Report Preparation:

Please review the adjustments and findings from your FY23 desk review or full scope engagement performed by our contractor, EisnerAmper LLP. You should incorporate all applicable findings and adjustments noted in your adjusted FY23 cost report into your FY24 cost report. Your cost report preparer/accountant should review the cost report instructions in the ADHC Provider Manual and the excel template in order to comply with LDH regulations regarding cost report preparation.

3. Cost Report Version:

All Louisiana Medicaid ADHC cost reports are to be completed using the most recent version of the Microsoft Excel template, **version 3.6 dated 7/3/2024.**
Cost reports submitted using an outdated version of the Microsoft Excel template will be rejected as incomplete and will not satisfy the requirements for timely filing. The most recent version of the Medicaid ADHC cost report is located on the web at:

https://myersandstauffer.com/client-portal/louisiana/louisiana-case-mix/#toggle-id-3

4. Cost Report Submission and Upcoming Cost Report Web Portal:

The Myers and Stauffer web portal must be utilized to file your cost report. This web portal is distinct from any other Myers and Stauffer hosted web portal that facilities may currently be using, and is a secure method of submitting Protected Health Information (PHI).
Before sending cost reports or supporting documents electronically:

- Review the file name format requirements listed at the bottom of the template Cover tab.
- Review all files for readability and legibility.
- If the provider chooses to print spreadsheets to PDF files prior to submission:
  - Do not reduce files below 50% reduction
  - Use appropriate page orientation (portrait vs. landscape) for each file
  - Include row and column headings on each page
- All PHI must be submitted in a secure, HIPAA compliant manner.
  - The Myers and Stauffer Cost Report Web Portal contains a built-in, secure uploading system and must be used for the submission of all PHI supporting documentation.
- All applicable attachments list in the Cover tab of the excel template must be submitted with the excel template in order for the cost report submission to be considered complete.

Our contractor, Myers and Stauffer, is available to answer your questions or assist you if software problems are encountered. The contractor can be reached at (800) 374-6858. Cost report training is located on the LDH Rate Setting and Audit Section website at https://ldh.la.gov/index.cfm/newsroom/detail/1573 . On that page, under "Related FILES", select: "ADHC Cost Report Training 8-13-2013 Entire Book".

If cost reports and all accompanying forms are not received by Myers and Stauffer by **September 30, 2024**, a penalty may be assessed. A penalty of 5% of the total weekly

payment for each week of non-compliance may be imposed until the completed cost report is received. The penalty may be increased an additional 5% each month until the completed cost report is submitted to **Myers and Stauffer. All penalties are non-refundable.**

If the calculation of the Direct Care Cost Settlement shows money due to the Department, do not remit payment with the cost report. The provider will be notified of the amount due after desk review or audit.

The maximum salary limits for the fiscal year 2024 are based on the State Civil Service maximums: Administrator: MR/DD Regional Associate Administrator 3 - $105,206 and Assistant Administrator: MR/DD Regional Associate Administrator 1 - $85,883.

Protected Health Information (PHI) and Personally Identifiable Information (PII) –

Please be aware that Protected Heath Information (PHI) should not be submitted to Myers & Stauffer in an unsecured format. Any information that can be used to identify an individual is considered PHI. It would be prudent to review your internal company policy and procedures in regards to the secure transfer of documents containing PHI. This should also be considered with Personally Identifiable Information (PII) which includes things such as W-2 records for employees. For any documents containing PHI or PII, you should only submit the minimum required support. Please note that standard email is not secure and therefore not HIPAA compliant. Any documents that Myers and Stauffer receives that contain PHI or PII and have not been secured will be reported to Myers and Stauffer's HIPAA Compliance Committee. Please let Myers and Stauffer know if you have any questions by contacting them at (800) 374-6858.

Should you have any questions about submission of the cost report you can contact Lindsey Nizzo, Medicaid Program Manager at (225) 342-3613 or via e-mail at lindsey.nizzo@la.gov .

Attachment

LNN

c: Dan Brendel
Kirsten Clebert
Mary J. Mason
Catie Mellott
Mary Norris
Missy Peroyea

Tizi Robinson
Chrisy Johnson
Anissa Young-Ned
Angela Burrell

ADHC Rate components for 07/1/2023 – 06/30/2024

Direct Care	$	2.08	per quarter hour
Care-Related	$	0.30	per quarter hour
Admin/OP	$	0.98	per quarter hour
Property	$	0.12	
Sub-total	$	3.48	
Transportation provided	$		per quarter hour regardless if transportation

Webinar will begin shortly!

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Training for Louisiana Adult Day Health Care Cost Report Template Updates

Presented By:
Kayla McCully

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

HOUSEKEEPING

MUTE

All lines have been muted for the duration of this training.

QUESTIONS

Feel free to ask questions using the chat feature at any point during today's session.

HELP

Ask a question using the chat feature or email LACostReports@mslc.com

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

AGENDA

- TRAINING OBJECTIVES
- RESOURCES
- SUBMISSION TIMELINE AND REQUIREMENTS
- FY2023 TEMPLATE UPDATES: Health Status Monitoring & Meal Delivery
  - SCHEDULE B UPDATES
  - SCHEDULE H UPDATES
  - SCHEDULE K UPDATES

General Training Objectives

- Discuss the FY2023 Submission Timeline and Requirements
- Provide an overview of the FY2023 ADHC Cost Report Template updates related to Health Status Monitoring and Meal Delivery
  - Schedule B
  - Schedule H
  - Schedule K

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Resources

https://myersandstauffer.com/client-portal/louisiana/louisiana-case-mix/

- LA ADHC Cost Report Template v3.5 dated 1/3/2024
- Recorded Webinar

https://ldh.la.gov/news/1573

- ADHC Filing Letters
- ADHC Training Resources

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

FY 2023 Submission Requirements

- **Submission Timeline**
  - Cost Report Period: **July 1, 2022 – June 30, 2023**
  - Revised Due Date: **March 15, 2024**
- **Submission Requirements**
  - All ADHC cost reports are to be completed using the most recent version of the template: **version 3.5 dated 1/3/2024**
  - All ADHC cost reports **must** be submitted via the Myers and Stauffer cost report web portal

FY 2023 Submissions: Questions?

FY2023 Cost Report Template Updates

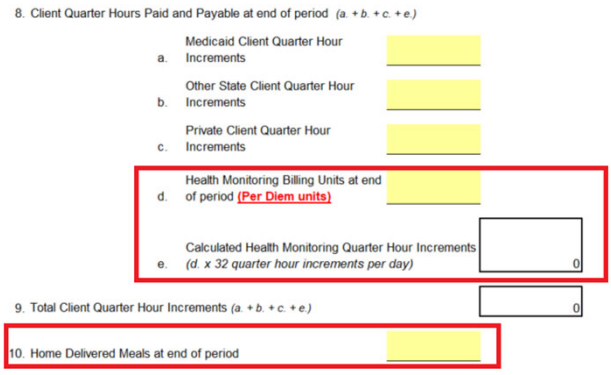
Health Status Monitoring & Meal Delivery

FY 2023 Cost Report Template Updates

- **Background:**
  - Meal Delivery and Health Monitoring/Health Status Monitoring were started as a result of the public health emergency related to COVID-19.
  - As such, the treatment of these expenses and revenues within the cost report fell outside of normal reporting procedures.
  - LDH, OAAS, P&N and M&S have worked congruently to update the FY 2023 template to properly collect this information.

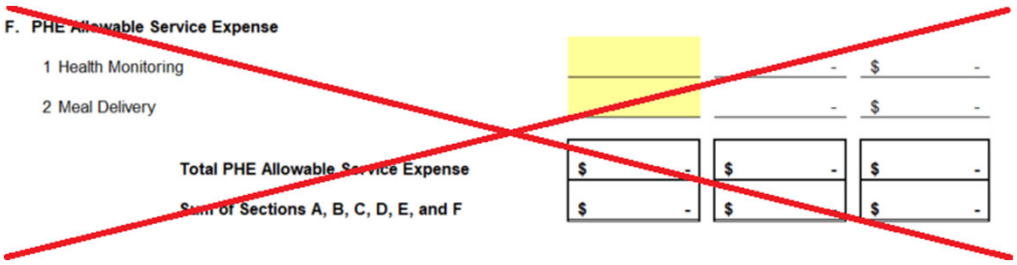
FY 2023 Cost Report Template Updates

- **FY2023 Updates to Schedule B**
  - Line 8d – Health Monitoring Billing Units at end of period (**Per Diem units**)
  - Line 8e (Calculated Field) – Health Monitoring Quarter Hour Increments (*8d x 32 quarter hour increments per day*)
  - Line 10 – Home Delivered Meals at end of period



FY 2023 Cost Report Template Updates

- **FY2023 Updates to Schedule H**
  - Lines F1 and F2 have been removed from the FY2023 cost report template.
  - Expenses related to Health Status Monitoring and Home Delivered Meals should be reported in Sections A, B and E as appropriate.



FY 2023 Cost Report Template Updates

- **FY2023 Updates to Schedule K**
- In order to properly calculate the Direct Care Cost Settlement, additional considerations had to be made related to the Health Status Monitoring service. The updates to Schedule K include:
  - Modification of old settlement calculation to be specific to ADHC only services
  - Addition of a Health Status Monitoring Direct Care Floor calculation section
    - Per decision from LDH, it is assumed that 10% of the HSM per diem ($47.35) relates to Direct Care.

FY 2023 Cost Report Template Updates

SCHEDULE K - Direct Care Cost Settlement

Provider's As-Submitted Data

FY2022 Template

			(a) Medicaid Quarter Hour Increments		(b) Direct Care Rate Component		(c) Medicaid Direct Care Revenue	(d) Medicaid Direct Care Revenue 70%
1a.	7/1/2021	- 6/30/2022		x	$ 1.56	=	$ -	$ -
1b.	n/a	- n/a			$ -	=	$ -	$ -
1c.	n/a	- n/a		x	$ -	=	$ -	$ -
			-				$ -	$ -

		(a) Medicaid Quarter Hour Increments		(b) Direct Care Costs Per Quarter Hour Increment		(c) Medicaid Direct Care Allowable Cost
2.	Actual Cost	0	x	$ -	=	$ -
3.	Due to State	Subtract Line 2, Col. (c) from Line 1, Col. (d) (if less than zero, enter zero)				$ -

SCHEDULE K - Direct Care Cost Settlement

Provider's As-Submitted Data

FY2023 Template

ADHC Direct Care Floor

			(a) ADHC Medicaid Quarter Hour Increments		(b) ADHC Direct Care Rate Component		(c) ADHC Medicaid Direct Care Revenue	(d) ADHC Medicaid Direct Care Revenue 70%
1a.	7/1/2022	- 6/30/2023		x	$ 2.08	=	$ -	$ -
1b.	n/a	- n/a			$ -	=	$ -	$ -
1c.	n/a	- n/a			$ -	=	$ -	$ -
			-				$ -	$ -

Health Status Monitoring Direct Care Floor

		(a) HSM Medicaid Quarter Hour Increments		(b) HSM Direct Care Rate Component		(c) HSM Medicaid Direct Care Revenue
2.		0	x	$ 0.15	=	$ -
3.	**Total Direct Care Floor (Line 1, Col. (d) plus Line 2, Col. (c))**					$ -

		(a) ADHC & HSM Medicaid Quarter Hour Increments		(b) Direct Care Costs Per Quarter Hour Increment		(c) ADHC & HSM Medicaid Direct Care Allowable Cost
4.	Actual Cost	0	x	$ -	=	$ -
5.	Due to State	Subtract Line 4, Col. (c) from Line 3 (if less than zero, enter zero)				$ -

FY 2023 CR Template Update Questions?

CONTACT US

LACostReports@mslc.com

OR

800-374-6858

Jeff Landry
GOVERNOR

Ralph L. Abraham, M.D.
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

M E M O R A N D U M

DATE: January 17, 2024

TO: Administrators of ADHC Facilities

FROM: Lindsey Nizzo, Medicaid Program Manager

SUBJECT: Submission of FYE 6-30-2023 ADHC Cost Reports

After extensive discussions with contractors and considering the delay in the accessibility of the cost report for FYE 2023, LDH will not be enforcing the penalty language for late cost report filings for 60 days from the original due date of September 30, 2023.

For this year's submission, annual cost reports (facility and central office) must be submitted by March 15, 2024 to avoid any late filing penalties (LAC 50:XXI:711). If cost reports and all accompanying forms are not received by Myers and Stauffer by this date, a penalty may be assessed. These reports cover the period of July 1, 2022 through June 30, 2023.

Attached are the ADHC payment system rate calculations. The Direct Care Component amount for dates of service 7/1/2022 to 6/30/2023 was $2.08 per quarter hour increment. This amount will be needed to prepare the Direct Care cost settlement.

Please note the following updates:

1. Meal Delivery and Health Monitoring:

For FY23, Schedule B – Stats has been updated to include lines 8.d., 8.e. and 10 to report the Health Monitoring Units and Home Delivered Meals which correspond to the revenues reported on Schedule G, Lines 2a and 2b. **It is critical that these new lines on Schedule B be completed accurately on your as-filed cost report. Inaccurate reporting of HSM and HDM statistics on Schedule B will impact the amount that is owed by the provider to LDH for FY 2023.**

Schedule H, Lines F1 and F2 have been removed from the FY23 cost report template, and providers should not attempt to differentiate the expenses related to these services at this time. These expenses should be reported alongside all other cost in the applicable A through E sections.

Schedule K has been modified to separately calculate the Direct Care Floor for the ADHC services and the Direct Care Floor for the Health Status Monitoring services (with the assumption from LDH that 10% of the $47.35 per diem rate is related to Direct Care). The actual cost for both services is then calculated and compared to the Total Direct Care Floor to determine if an amount is due to LDH.

2. Cost Report Version:

All Louisiana Medicaid ADHC cost reports are to be completed using the most recent version of the Microsoft Excel template, **version 3.5 dated 01/03/2024.** Cost reports submitted using an outdated version of the Microsoft Excel template will be rejected as incomplete and will not satisfy the requirements for timely filing. The most recent version of the Medicaid ADHC cost report is located on the web under the "Downloads" section at:

https://myersandstauffer.com/client-portal/louisiana/louisiana-case-mix/#toggle-id-12

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website at https://ldh.la.gov/index.cfm/newsroom/detail/1573 . On that page, under "Related FILES", select: "ADHC Cost Report Training 8-13-2013 Entire Book".

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Should you have any questions about submission of the cost report you can contact Lindsey Nizzo, Medicaid Program Manager at (225) 342-3613 or via e-mail at lindsey.nizzo@la.gov .

Attachment

LNN

c: Dan Brendel
Kirsten Clebert
Mary J. Mason
Catie Mellott
Mary Norris
Missy Peroyea
Tizi Robinson
Paul Rhorer
Jackie Cummings
Anissa Young-Ned

ADHC Rate components for 7/1/2022 – 6/30/2023

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Admin/OP	$	0.98	per quarter hour
Property	$	0.12	
Sub-total	$	3.48	
Transportation provided			per quarter hour regardless if transportation

LOUISIANA DEPARTMENT OF HEALTH

ADHC Bi-Annual Meeting

Office of Aging and Adult Services

3/26/2024

Agenda

- Welcome
- Introduction to Provider Relations Staff
- ADHC Cost Reporting Q&A
- Waiver Rules and Waiver Amendment Updates
- HCBS Access Rule Information

Introduction to Provider Relations Staff

Cheryl Dickerson Brown

New Provider Relations Staff

Iryn Butler

- Has worked with OAAS for over 5 years in other roles, including assisting provider relations with claims and Medicaid enrollment
- Works as provider liaison with all OAAS providers of OAAS services
- Manages billing claims issues
- Technical support to providers on policy and procedure questions

Eula Moore

- Has over 10 years experience with MCO claims
- Works as provider liaison with all OAAS providers of OAAS services
- Manages billing claims issues
- Technical support to providers on policy and procedure questions

ADHC Cost Reporting

Lindsey Nizzo (LDH Medicaid) and Missy Peroyea (EisnerAmper)

ADHC Cost Reporting

FY 2023 Cost reports:

- Due date was 3/15/24
- Changes to FY23 form:
  - Home Delivered Meals (HDM) statistics - Sch. B, Line 10
  - Health Status Monitoring (HSM) statistics - Sch. B, Line8d
  - No separate expense section for HDM or HSM
    - No change to HDM and HSM revenue reporting on Sch. G
  - Floor settlement includes HSM direct care @ 10%
    - ADHC direct care floor remains @ 70%
- Cost report audits for FY23 will begin in mid-April
- Cost report preparation training for 6/30/24 – Summer 2024
- Questions?

Waiver Rules and Waiver Renewal/Amendment Updates

Kirsten Clebert

ADHC Waiver & Community Choices Waiver Documents

The following was approved by CMS and has been implemented:

- SCAs conducting virtual visits/contacts

ADHC Waiver Documents

The following new services were approved by CMS and have been implemented:

- New covered services:
  - Home Delivered Meals
  - Activity and Sensor Monitoring
  - Personal Emergency Response System (PERS)
  - ADHC Health Status Monitoring
  - Assistive Technology (ARPA service)

ADHC Waiver Documents (cont'd)

ADHC Waiver Amendment was published on 3/20/24 for public comment.

- Allowing electronic signatures for assessment and care plan documents.

ADHC Waiver Rule

The following was updated in the ADHC Waiver rule and became a final rule effective 3/20/24.

- Adding details for new covered services:
  - Home Delivered Meals;
  - Activity and Sensor Monitoring;
  - Personal Emergency Response System; and
  - ADHC Health Status Monitoring

The Medicaid ADHC Waiver Provider Manual will soon be reissued with these services added to the applicable sections.

Community Choices Waiver (CCW) Rule

The following is being added to the CCW rule and was published as a Notice of Intent on 3/20/24.

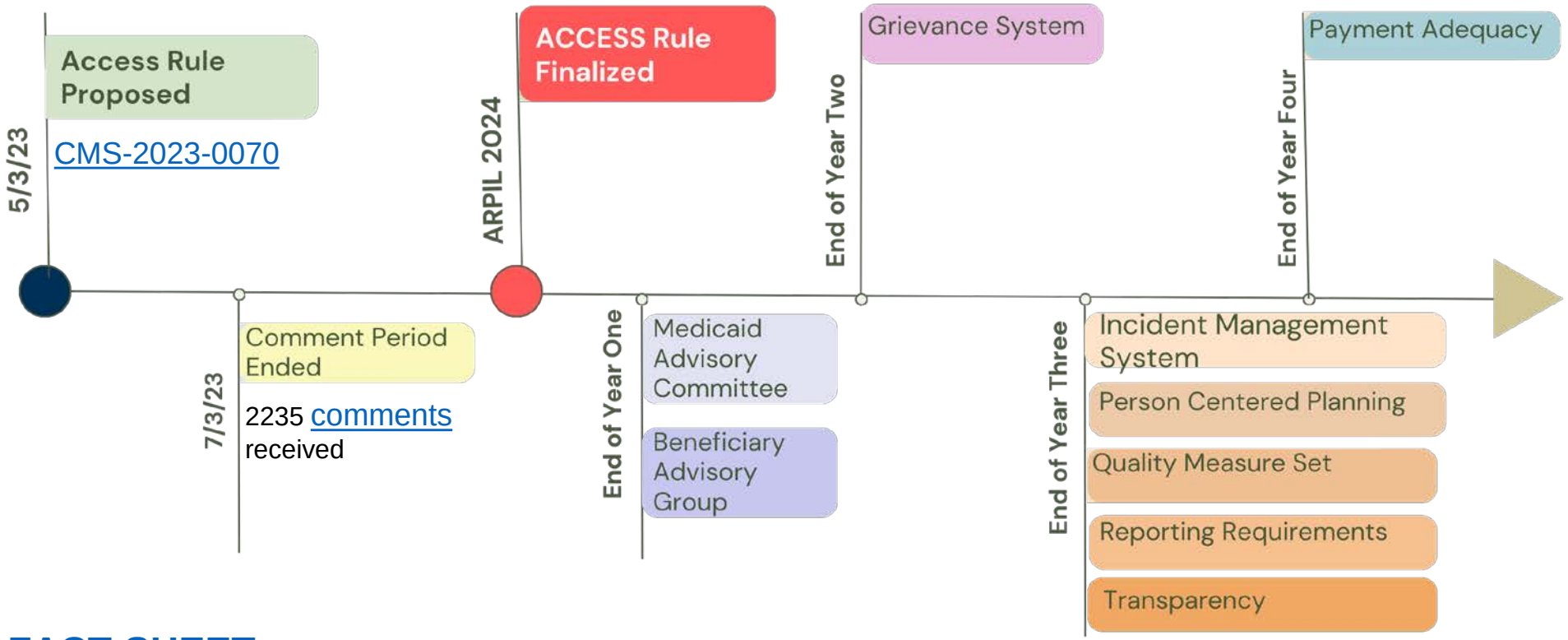
- CCW participants that receive Monitored In-Home Caregiving (MIHC) services can also receive ADHC services (just not on the same day).

LOUISIANA DEPARTMENT OF HEALTH

HCBS Access Rule

Tara DeLee

CMS "Ensuring Access to Medicaid Services" Proposed Rule



CMS FACT SHEET

**These requirements are "proposed" only and subject to change with the publication of the final rule.*

CMS "Ensuring Access to Medicaid Services" Proposed Rule

**These requirements are "proposed" only and subject to change with the publication of the final rule.*

ACCESS | QUALITY | TRANSPARENCY

Areas	Brief Description
Incident Management System	Federal definition; combined system across entities; annual assessments; 24 month reports.
HCBS Payment Adequacy	80% pass through for direct care staff; advisory groups
Person Center Planning	90% confidence level for annual assessments & plans of care
Grievance System	Sets resolution timelines (routine 90 days, expedited 14 days)
Advisory Committees	Medicaid Advisory Committee (MAC) & Beneficiary Advisory Group (BAG).
HCBS Quality Measures	New Quality Measures; State Medicaid Director Letter #22-003).
State Reporting Requirements	Report on measures every 24 months. • % of Medicaid payments to direct care workers and compliance with 80% minimum direct care worker requirement; • Access and timeliness for personal care, homemaker and home health aide services and annually reports on timeframes for service entry and authorized hours; • Average hourly direct care worker wages; • Quality Measure Set; • Critical Incidents & Incident Management System Assessment; • Person-Centered Planning; and • Waiting lists
Transparency	Webpage that makes all information available.

THANK YOU

OAAS

https://ldh.la.gov/OAAS

225-219-0223

OAAS.ProviderRelations@la.gov

LOUISIANA DEPARTMENT OF HEALTH

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Aging and Adult Services

MEMORANDUM

OAAS-P-22-016

TO: OAAS Adult Day Health Care Providers

FROM: Melinda Richard Melinda Richard
OAAS Assistant Secretary

DATE: September 30, 2022

SUBJECT: ADHC Rate Increases, Direct Support Worker Wage Floor, Other Wage and Non-Wage Benefits and Workforce Retention Bonus Payments

The Louisiana Department of Health (LDH) Office of Aging and Adult Services (OAAS) has authorized Adult Day Health Care (ADHC) rate increases, Direct Support Worker wage floor, other wage and non-wage benefits and workforce retention bonus payments. These payments have been made possible through approval of the American Rescue Plan Act (ARPA) of 2021. The updated information is described below in red.

Rate Increases

The reimbursement rate for ADHC services is being increased as detailed in the table below. Beginning August 10, 2022, claims for ADHC services provided on or after October 1, 2021 will be paid at the new rates.

ADHC claims with dates of service on or after October 1, 2021, previously submitted using the lower rates, will be automatically recycled. OAAS anticipates the claim recycle to begin in September and ADHC providers can expect to receive payments for the differences in the rates after this date.

ADHC rate increases will end when the State's funding authorized under ARPA is exhausted. However, OAAS will notify ADHC providers prior to this increased rate changing.

Adult Day Health Care Services (ADHC)		
Service:	**Procedure Code:**	**New Rate**
ADHC	S5100	$3.48 per 15 minutes plus provider specific transportation rate – Maximum of 40 units per day or 200 units per week

ADHC providers may access the updated fee schedule at the following link:

https://www.lamedicaid.com/Provweb1/fee_schedules/ADHC_Billing_Codes_Current.pdf

Direct Support Worker Wage Floor and Other Benefits

Beginning, September 1, 2022, ADHC providers must pay the direct support workers a minimum wage floor of $9.00 per hour.

Beginning October 1, 2022, ADHC providers must pass 70% of their rate increase directly to direct support workers in the form of a minimum wage floor of $9.00 per hour AND in other wage and non-wage benefits.

The minimum wage floor and other wage and non-wage benefits applies to all direct support workers of any working status, whether full-time or part-time.

ADHC providers must write a detailed policy, to be in place by October 1, 2022, that includes the specific methods that they will use to pass 70% of their rate increases to the direct support workers. OAAS has authorized (approved) the following wage and non-wage benefits:

- Increased wages above the minimum wage floor of $9.00 per hour, to include the increased (ONLY) employer associated costs for (payroll taxes, liability and workers compensation insurance, 401K or retirement savings);
- Bonuses, to include sign-on, recruitment and retention bonuses;
- Paid vacation leave;
- PPE;
- Paid sick leave;
- Gas mileage reimbursement;
- Training;
- Employer paid/supplemented health care insurance;
- Uniforms for DSWs and/or
- Overtime for DSWs and increased (ONLY) employer associated costs.

Any additional benefits/methods not listed above MUST be pre-approved by OAAS before the benefit is added to your agency's policy, or, prior to being provided to DSWs. Pre-approval must be requested by emailing OAAS at OAAS.ProviderRelations@LA.gov.

OAAS does not need to approve your agency's policy; only requests to use other benefits/methods not listed above will need to be sent to OAAS.

The ADHC minimum wage floor and other wage and non-wage benefits will end when the State's funding authorized under ARPA is exhausted. However, OAAS will notify ADHC providers prior to the wage floor and wage and non-wage benefits ending.

Direct Support Worker Workforce Retention Bonus Payments

ADHC providers that were providing ADHC services on or after April 1, 2021 will receive a bonus payment of $150 per month for each direct support worker that provided direct care to participants for at least 16 hours each month. ADHC providers will pay the direct service worker at least $125 of the $150 monthly bonus payment.

These bonus payments are effective for all direct support workers of any working status, whether full-time or part-time. If a direct support worker works for more than one provider agency, the State will determine which provider agency will receive the bonus payment. A DSW is eligible for only one bonus payment per month.

OAAS will notify ADHC providers once the bonus payment start date is determined.

These bonus payments will end when the State's funding authorized under ARPA is exhausted. However, OAAS will notify ADHC providers prior to the bonus payments ending.

Direct Support Worker Wage Floor, Other Wage and Non-Wage Benefits, and Workforce Retention Bonus Payments Audit Process

In accordance with receiving the ARPA funding, LDH/OAAS must provide reassurance to the Federal Government that the $9.00 minimum wage floor and other wage and non-wage benefits are implemented and bonus payments are disbursed to each eligible DSW.

In order to verify that the wage floor, other wage and non-wage benefits, and bonus payments are being implemented or disbursed to appropriate direct support workers, OAAS will send letters to the ADHC providers requesting documentation that confirms that these incentives/payments were implemented and paid accurately and according to the Rule.

OAAS is requesting that each ADHC provider maintain payroll records to assist OAAS with the completion of these audits, as well as documentation to support the provision of all non-wage benefits documented in policy and provided to direct support workers. If additional documentation is required, OAAS will provide prompt notice to ADHC providers.

If you have any questions regarding these memorandum, please email the OAAS Provider Relations staff member at OAAS.ProviderRelations@LA.gov.

c: OAAS Regional Offices
Statistical Resources, Inc.
OAAS Support Coordination Agencies (SCAs)
Medicaid Programs Support and Waivers (MPSW)

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
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MEMORANDUM

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c: OAAS Regional Offices
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OAAS Support Coordination Agencies (SCAs)
Medicaid Programs Support and Waivers (MPSW)

John Bel Edwards
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SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

M E M O R A N D U M

DATE: August 22, 2022

TO: Administrators of ADHC Facilities

FROM: Lindsey Nizzo, Medicaid Program Manager

SUBJECT: Submission of FYE 6-30-2022 ADHC Cost Reports

This letter is to remind you that annual cost reports (facility and central office) must be submitted by **September 30, 2022.** These reports cover the period of July 1, 2021 through June 30, 2022.

Attached are the ADHC payment system rate calculations. The Direct Care Component amount for dates of service 7/1/2021 to 9/30/2021 was $1.56 per quarter hour increment. The Direct Care Component amount for dates of service 10/1/2021 to 6/30/2022 was $2.08. This amount will be needed to prepare the Direct Care cost settlement.

Please note the following updates:

1. Meal Delivery and Health Monitoring:

These services were started during 2020 as a result of the pandemic emergency. Expenses related to these services must be reported on the cost report, and then offset by an adjustment for revenues received for these services.

For FY22, there are 4 new cost report lines for reporting the revenue and expenses related to these services:

1. Schedule G, Line 2a – Health Monitoring Revenue
2. Schedule G, Line 2b – Meal Delivery Revenue
3. Schedule H, Line F1 – Health Monitoring Expense
4. Schedule H, Line F2 – Meal Delivery Expense

2. Cost Report Version:

All Louisiana Medicaid ADHC cost reports are to be completed using the most recent

version of the Microsoft Excel template, **version 3.4 dated 6/13/2022.**
Cost reports submitted using an outdated version of the Microsoft Excel template will be rejected as incomplete and will not satisfy the requirements for timely filing. The most recent version of the Medicaid ADHC cost report is located on the web at:

https://myersandstauffer.com/client-portal/louisiana/louisiana-case-mix/#toggle-id-3

3. Cost Report Submission and Upcoming Cost Report Web Portal:

The Myers and Stauffer web portal must be utilized to file your cost report. This web portal is distinct from any other Myers and Stauffer hosted web portal that facilities may currently be using, and is a secure method of submitting Protected Health Information (PHI).
Before sending cost reports or supporting documents electronically:

- Review the file name format requirements listed at the bottom of the template Cover tab.
- Review all files for readability and legibility.
- If the provider chooses to print spreadsheets to PDF files prior to submission:
  - Do not reduce files below 50% reduction
  - Use appropriate page orientation (portrait vs. landscape) for each file
  - Include row and column headings on each page
- All PHI must be submitted in a secure, HIPAA compliant manner.
  - The Myers and Stauffer Cost Report Web Portal contains a built-in, secure uploading system and must be used for the submission of all PHI supporting documentation.
- All applicable attachments list in the Cover tab of the excel template must be submitted with the excel template in order for the cost report submission to be considered complete.

Our contractor, Myers and Stauffer, is available to answer your questions or assist you if software problems are encountered. The contractor can be reached at (800) 374-6858. Cost report training is located on the LDH Rate Setting and Audit Section website at https://ldh.la.gov/index.cfm/newsroom/detail/1573 . On that page, under "Related FILES", select: "ADHC Cost Report Training 8-13-2013 Entire Book".

If cost reports and all accompanying forms are not received by Myers and Stauffer by **September 30, 2022**, a penalty may be assessed. A penalty of 5% of the total weekly payment for each week of non-compliance may be imposed until the completed cost report is received. The penalty may be increased an additional 5% each month until the completed cost report is submitted to **Myers and Stauffer. All penalties are non-refundable.**

If the calculation of the Direct Care Cost Settlement shows money due to the Department, do not remit payment with the cost report. The provider will be notified of the amount due after desk review or audit.

The maximum salary limits for the fiscal year 2022 are based on the State Civil Service maximums: Administrator: MR/DD Regional Associate Administrator 3 - $105,206 and Assistant Administrator: MR/DD Regional Associate Administrator 1 - $85,883.

Protected Health Information (PHI) and Personally Identifiable Information (PII) –

Please be aware that Protected Heath Information (PHI) should not be submitted to Myers & Stauffer in an unsecured format. Any information that can be used to identify an individual is considered PHI. It would be prudent to review your internal company policy and procedures in regards to the secure transfer of documents containing PHI. This should also be considered with Personally Identifiable Information (PII) which includes things such as W-2 records for employees. For any documents containing PHI or PII, you should only submit the minimum required support. Please note that standard email is not secure and therefore not HIPAA compliant. Any documents that Myers and Stauffer receives that contain PHI or PII and have not been secured will be reported to Myers and Stauffer's HIPAA Compliance Committee. Please let Myers and Stauffer know if you have any questions by contacting them at (800) 374-6858.

Should you have any questions about submission of the cost report you can contact Lindsey Nizzo, Medicaid Program Manager at (225) 342-3613 or via e-mail at lindsey.nizzo@la.gov .

Attachment

LNN

c: Dan Brendel
Kirsten Clebert
Mary J. Mason
Catie Mellott
Mary Norris
Missy Peroyea
Andrew Perilloux
Tizi Robinson
Paul Rhorer
Anissa Young-Ned

ADHC Rate components for 7-1-2021 to 9-30-2021

Direct Care	$	1.56	per quarter hour
Care-Related	$	0.28	per quarter hour
Admin/OP	$	0.58	per quarter hour
Property	$	0.14	per quarter hour
Sub-total	$	2.56	
Transportation			

ADHC Rate components for 10/1/2021 – 6/30/2022

Direct Care	$	2.08	per quarter hour
Care-Related	$	0.30	per quarter hour
Admin/OP	$	0.98	per quarter hour
Property	$	0.12	per quarter hour
Sub-total	$	3.48	
Transportation			per quarter hour regardless if transportation provided

John Bel Edwards
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Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

M E M O R A N D U M

DATE: **November 3, 2021**

TO: Administrators of ADHC Facilities

FROM: Lindsey Nizzo, Medicaid Program Manager

SUBJECT: Submission of FYE 6-30-2021 ADHC Cost Reports

After extensive discussions with contractors and ADHC providers, and considering the continued pandemic and recent weather events, LDH will not be enforcing the penalty language for late cost report filings for **60 days from the original due date of September 30, 2021**. This is aimed at assisting ADHC providers who are already struggling with meeting program requirements, as well as avoid any access to care issues.

For this year's submission, annual cost reports (facility and central office) must be submitted by December 1, 2021 to avoid any late filing penalties (LAC 50:XXI:711). If cost reports and all accompanying forms are not received by Myers and Stauffer by this date, a penalty may be assessed. These reports cover the period of July 1, 2020 through June 30, 2021. Please note that if you have billed Medicaid sources less than 25 quarter hour increments during the cost reporting period, you must sign and submit the attached attestation statement in lieu of a completed cost report, and no completed cost report is required.

Attached are the ADHC payment system rate calculations. The Direct Care Component amount was $1.56 per quarter hour increment. This amount will be needed to prepare the Direct Care cost settlement.

Please note the following updates:

1. Meal Delivery and Health Monitoring:

   These services were started during the past year as a result of the pandemic emergency. Expenses related to these services must be captured on the cost report, and then offset via adjustment for revenues received for these services. Providers may classify these services based on their own working trial balance crosswalk but the expenses must be offset by the revenue received for these services.

2. Cost Report Version:

   All Louisiana Medicaid ADHC cost reports are to be completed using the most recent version of the Microsoft Excel template, **version 3.3 dated 09/17/2021.**

   Cost reports submitted using an outdated version of the Microsoft Excel template will be rejected as incomplete and will not satisfy the requirements for timely filing. The most recent version of the Medicaid ADHC cost report is located on the web at:

   https://www.mslc.com/Louisiana/CaseMix.aspx

3. Cost Report Submission and Upcoming Cost Report Web Portal:

   The Myers and Stauffer web portal must be utilized to file your cost report. This web portal is distinct from any other Myers and Stauffer hosted web portal that facilities may currently be using, and is a secure method of submitting Protected Health Information (PHI).

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Should you have any questions about submission of the cost report you can contact Lindsey Nizzo, Medicaid Program Manager via e-mail: Lindsey.Nizzo@la.gov .

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c: Dan Brendel
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Mary J. Mason
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Mary Norris
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Property	$	0.14	per quarter hour
Sub-total	$	2.56	
Transportation			Facility Specific Rate per quarter hour regardless if transportation provided

Low Utilization Attestation Statement

I, Name, Administrative Title of Facility Name in City, State attest that for the cost report period beginning July 1, 2020 and ending June 30, 2021 there were less than 25 Quarter Hour Increments billed across all payer types. As a result, no cost report will be submitted. I understand that if the Louisiana Department of Health discovers that my facility did bill more than 25 quarter hour increments across all payer types during the cost report period for July 1, 2020 and June 30, 2021, that I must complete and submit an appropriate cost report, and I will be responsible for any penalties for delinquent filing as determined by the Louisiana Department of Health.

_____ _____

SIGNATURE Date

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Legal Services

HEALTHCARE FACILITY NOTICE

EMERGENCY ORDER
COVID19-ADC/ADHC/PACE

FOR IMMEDIATE RELEASE

TO: Adult Day Care (ADC) Providers
Adult Day Health Care (ADHC) Providers
PACE Providers

FROM: LDH Office of Public Health
Joseph Kanter, M.D.
State Health Officer

RE: State Health Officer Order

DATE: May 14, 2021

EFFECTIVE DATES: This Emergency Order shall be effective immediately, beginning 7:00 a.m. on Monday, May 17, 2021, and shall remain in effect until further notice from the State Health Officer.

RATIONALE AND LEGAL AUTHORITY:

On January 30, 2020, the International Health Regulations Emergency Committee of the World Health Organization declared the COVID-19 outbreak a "public health emergency of international concern" (PHEIC). On January 31, 2020, Health and Human Services Secretary, Alex M. Azar II declared a public health emergency (PHE) for the United States effective January 27, 2020. Pursuant to the Louisiana Health Emergency Powers Act, R.S. 29:760, *et seq.*, a state of public health emergency resulting from the outbreak of "coronavirus disease 2019" ("COVID-19") was declared to exist in the entire State of Louisiana by Proclamation Number 25 JBE 2020.

The COVID-19 outbreak in Louisiana continues. Measures are necessary to protect the health and safety of the public. The measures ordered herein are in line with the best guidance and direction form the Centers for Medicare and Medicaid Services (CMS) and/or the U.S. Centers for Disease Control and Prevention (CDC).

The State Health Officer expressly finds that the measurers ordered herein are necessary to help control and prevent further spread of COVID-19, a communicable, contagious, and infectious disease that represents a serious and imminent threat to the public health.

NOW THEREFORE, pursuant to the powers vested in me by L.R.S. 40:1 et seq., particularly La. R.S. 40:4(A)(13) and La. R.S. 40:5(A)(2), I, Joseph Kanter, M.D., State Health Officer, do hereby issue the following emergency order:

(1) All ADC, ADHC and PACE providers in Louisiana are eligible to re-open at 100% capacity.

(2) If a client/participant or staff of the ADC, ADHC, or PACE is fully vaccinated, they do not need to wear a mask or social distance while at the facility. If a client or staff is not fully vaccinated, they do need to continue to wear a mask and social distance while at the facility. If a client/participant or staff is fully vaccinated and chooses to wear a mask and social distance, they are allowed to do so.

(3) Any ADC, ADHC, or PACE provider may impose stricter policies than mandated in this Order if the facility chooses, provided that the facility have a policy and procedure in place to address such restrictions.

(4) This State Health Officer Order replaces and supersedes any previously issued State Health Officer orders/notices to ADC providers, ADHC providers, and PACE providers, regarding closure and re-opening.

(5) This State Health Officer Order does not mandate that any ADC provider, ADHC provider, or PACE provider re-open.

(6) This State Health Officer Order does not mandate that any client or participant return to an ADC, an ADHC, or PACE Center.

(7) Any ADHC provider that provides transportation to clients/participants shall follow the same protocols as identified in Number (2) above while any clients, participants and staff are in the vehicle.

(8) The State Health Officer reserves the right to modify this order should COVID-19 transmission levels change in Louisiana.

(9) The Louisiana Department of Health will revise the re-opening guidance attached to the State Health Officer Order #2020-COVID-19-ADC/ADHC/PACE-002, dated October 2, 2020, soon and will disseminate that guidance once complete.

(10) If local ordinances and/or COVID-19 restrictions are more stringent than this order, the ADC, ADHC and PACE providers shall follow any local ordinance and/or COVID-19 restrictions.

BY: Joseph Kanter, M.D. 5/14/21

Joseph Kanter, M.D. Date

Concurrence:

Dr. Courtney N. Phillips May 14, 2021

Dr. Courtney N. Phillips Date

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Aging and Adult Services

MEMORANDUM **OAAS-P-20-033**

TO: **Adult Day Health Care (ADHC) Providers**

FROM: **Sherlyn Sullivan, OAAS Interim Assistant Secretary**

DATE: **August 19, 2020**

SUBJECT: **Updates to ADHC Providers Regarding Home Delivered Meals and Per Diem Payment for ADHC Health Status Monitoring**

This memorandum is to inform Adult Day Health Care (ADHC) providers that the Office of Aging and Adult Services (OAAS) has been approved by the federal government to allow ADHC providers to receive Medicaid payments for Home Delivered Meals and Health Status Monitoring due to the COVID-19 emergency and the continuation of the ADHC center closures.

Effective immediately, ADHC providers may begin billing for these services. Below are the specific billing guidelines:

Home Delivered Meals Under the ADHC Waiver ONLY:

- ADHC providers are now listed as a Home Delivered Meals provider type under the **ADHC Waiver ONLY**.

- ADHC providers who are delivering meals should contact the ADHC Waiver participant's support coordinator and request a Plan of Care (POC) Revision. The support coordinator will verify this request with the participant and document this accordingly on the Support Coordination Documentation (SCD) form. The POC Revision should identify the number of meals provided per day and per week by the ADHC provider. For ADHC providers who have been delivering meals, the POC Revision may be retroactive to Tuesday, July 7, 2020.

- POC Revisions must be completed by the SC as soon as possible and must be completed within two (2) weeks of notification/request by the ADHC provider.

- The procedure code for Home Delivered Meals is S5170 and billing must be performed through DXC. ADHC providers should use their current ADHC provider number to bill for this service.

- Meals may be provided to participants up to twice a day for no more than 7 days a week at a rate of no more than $7.00 per meal. Please note that once ADHC centers are allowed to re-open, ADHC providers **will not** be able to bill for Home Delivered Meals on days that the participant attends the ADHC in person.

- ADHC Waiver participants may receive meals from both the ADHC provider and another authorized Home Delivered Meal provider, as long as they do not exceed the limits stated above.

- In providing home delivered meals, ADHC providers must follow: Guidance for Home Delivered Meals-Prepared in the ADHC center's Kitchen and Delivered by ADHC Personnel or Volunteers

ADHC Health Status Monitoring Per Diem Under the ADHC Waiver and Community Choices Waiver (CCW):

- ADHC providers may begin billing a per diem for Health Status Monitoring retroactive to Monday, August 17, 2020 for participants under both the ADHC Waiver and the Community Choices Waiver (CCW). A Plan of Care (POC) Revision **is not needed** for ADHC providers to begin delivering and billing for this service.

- The procedure code for this new service is S5102. The same Prior Authorization (PA) number used for S5100 (ADHC center-based services) will be used for S5102 (ADHC Health Status Monitoring Per Diem).

- This per diem rate is $47.35.

- In order for ADHC providers to bill this per diem, they must complete the following:

  - Make contact* **every other day (including weekends)** to determine if the participant:

    *Contact may be via telephone, secure video or conferencing platform, or at the participant's home. Video and/or conferencing

software must comply with CMS guidance for use of such technology during the current public health emergency.

- Has enough food and fluids;
- Has access to and is taking his/her prescribed medications; and
- Has essential supplies.

- Provide follow-up on any need identified during the telephone contact.
- Remind participants to contact their doctor if they do not feel well.
- Document the actual times (Example: 8:00 a.m. - 8:15 a.m.) of this contact in the LaSRS, Electronic Visit Verification (EVV) system using **"ADHC Health"** for the service type.
- Record details of this contact in the participant's progress notes that are part of the participant's record that is kept by the ADHC provider.

- ADHC providers should contact participants every other day. Providers will be limited to 4 contacts/encounters per week with a maximum of 16 contacts/encounters per month.

  NOTE: Once the ADHC centers re-open, participants will be limited to 5 contacts/encounters or total days listed on the participants' Plan of Care (POC). An encounter is either the Health Status Monitoring OR the participant attending the ADHC center in person. ADHC providers may only bill for one encounter per day (Health Status Monitoring Per Diem rate OR regular ADHC center-based service rate).

- ADHC providers must use the LaSRS, EVV system in order for SRI to release a billing unit.

- ADHC providers may bill for Health Status Monitoring Per Diem and Home Delivered Meals on the same day.

- Once the ADHC centers re-open, ADHC providers must contact the participant's support coordinator and request a POC Revision for the participant. This POC Revision will need to indicate the specific days for when the participant attends the ADHC in person or the ADHC provider conducts Health Status Monitoring.

If you have any questions, please contact OAAS.ProviderRelations@la.gov.

c: OAAS Regional Offices
OAAS Support Coordination Agencies
Statistical Resources, Inc.
Medicaid Program Support and Waivers

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

M E M O R A N D U M

DATE: August 4, 2020

TO: Administrators of ADHC Facilities

FROM: Denis S. Beard, Medicaid Program Manager

SUBJECT: Submission of FYE 6-30-2020 ADHC Cost Reports

This letter is to remind you that annual cost reports (facility and central office) must be submitted by September 30, 2020. These reports cover the period of July 1, 2019 through June 30, 2020.

Attached are the ADHC payment system rate calculations. The Direct Care Component amount was $1.56 per quarter hour increment. This amount will be needed to prepare the Direct Care cost settlement.

Please note the following updates:

1. Cost Report Version:

   All Louisiana Medicaid ADHC cost reports are to be completed using the most recent version of the Microsoft Excel template, **version 3.2 dated 06/05/2020.**

   Cost reports submitted using an outdated version of the Microsoft Excel template will be rejected as incomplete and will not satisfy the requirements for timely filing. The most recent version of the Medicaid ADHC cost report is located on the web at:

   https://www.mslc.com/Louisiana/CaseMix.aspx

2. Cost Report Submission and Upcoming Cost Report Web Portal:

   Myers and Stauffer is currently in the process of setting up a cost report web portal for use by ADHCs to submit cost reports and supporting documentation. This web portal will be distinct from any other Myers and Stauffer hosted web portal that facilities may currently be using, and will be a secure method of

submitting Protected Health Information (PHI). Myers and Stauffer will reach out to facilities in the near future to collect contact information necessary for registration and credentialing. Additionally, a training session and materials on web portal use will be provided by Myers and Stauffer. Once the web portal is available for use, it will be the preferred method of submission for all cost reports and related supporting documentation.

Cost Report files and all support MUST be submitted electronically to Myers & Stauffer using one of the following methods:

- Via the Myers and Stauffer Cost Report Web Portal. This will be the preferred method of data submission.
- Via e-mail: (LACostReports@mslc.com).

Before sending cost reports or supporting documents electronically:

- Review the file name format requirements listed at the bottom of the template Cover tab.
- Review all files for readability and legibility.
- If the provider chooses to print spreadsheets to PDF files prior to submission:
    - Do not reduce files below 50% reduction
    - Use appropriate page orientation (portrait vs. landscape) for each file
    - Include row and column headings on each page
- All PHI must be submitted in a secure, HIPAA compliant manner.
    - Please note that standard email is not secure and therefore not HIPAA compliant.

The Myers and Stauffer Cost Report Web Portal will be the preferred method as it contains a built-in, secure uploading system

Our contractor, Myers and Stauffer, is available to answer your questions or assist you if software problems are encountered. The contractor can be reached at (800) 374-6858. Cost report training is located on the LDH Rate Setting and Audit Section website at https://ldh.la.gov/index.cfm/newsroom/detail/1573 . On that page, under "Related FILES", select: "ADHC Cost Report Training 8-13-2013 Entire Book".

If cost reports and all accompanying forms are not received by Myers and Stauffer by September 30, 2020, a penalty may be assessed. A penalty of 5% of the total weekly payment for each week of non-compliance may be imposed until the completed cost report is received. The penalty may be increased an additional 5% each month until the completed cost report is submitted to **Myers and Stauffer. All penalties are non-refundable.**

If the calculation of the Direct Care Cost Settlement shows money due to the Department, do not remit payment with the cost report. The provider will be notified of the amount due after desk review or audit.

The maximum salary limits for the fiscal year 2020 are based on the State Civil Service maximums: Administrator: MR/DD Regional Associate Administrator 3 - $105,206 and Assistant Administrator: MR/DD Regional Associate Administrator 1 - $85,883.

Protected Health Information (PHI) and Personally Identifiable Information (PII) –

Please be aware that Protected Heath Information (PHI) should not be submitted to Myers & Stauffer in an unsecured format. Any information that can be used to identify an individual is considered PHI. It would be prudent to review your internal company policy and procedures in regards to the secure transfer of documents containing PHI. This should also be considered with Personally Identifiable Information (PII) which includes things such as W-2 records for employees. For any documents containing PHI or PII, you should only submit the minimum required support. Please note that standard email is not secure and therefore not HIPAA compliant. Any documents that Myers and Stauffer receives that contain PHI or PII and have not been secured will be reported to Myers and Stauffer's HIPAA Compliance Committee. Please let Myers and Stauffer know if you have any questions by contacting them at (800) 374-6858.

Should you have any questions about submission of the cost report you can contact Denis S. Beard, Medicaid Program Manager at (225) 342-3613 or via e-mail at denis.beard@la.gov .

Attachment

DSB

c: Dan Brendel
Kirsten Clebert
Mary J. Mason
Catie Mellott
Mary Norris
Missy Peroyea
Andrew Perilloux
Paul Rhorer
Anissa Young-Ned

ADHC Rate components for 7-1-2019 to 6-30-2020

Direct Care	$	1.56	per quarter hour
Care-Related	$	0.28	per quarter hour
Admin/OP	$	0.58	per quarter hour
Property	$	0.14	per quarter hour
Sub-total	$	2.56	
Transportation			per quarter hour regardless if transportation provided

John Bel Edwards
GOVERNOR

Stephen R. Russo, JD
INTERIM SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Aging and Adult Services
Office for Citizens with Developmental Disabilities

MEMORANDUM

OCDD-P-20-011
OAAS-P-20-009

Multiple additional monthly letters (not included) were issued between March and October continuing the closure until October

DATE: **March 22, 2020**

TO: **Adult Day Care (ADC) Providers**
Adult Day Health Care (ADHC) Providers
Program for All-Inclusive Care of the Elderly (PACE) Providers

FROM: **Sherlyn Sullivan, OAAS Interim Assistant Secretary**
Julie Foster Hagan, OCDD Assistant Secretary

SUBJECT: **Program Closures**

To protect the health and safety of individuals during the COVID-19 public health emergency, all ADC, ADHC and PACE providers state-wide shall **CLOSE** their day centers effective 5:00 PM, March 23, 2020 and will remain closed through the end of the night on Sunday, April 12th, unless otherwise extended by written notice from the Department. PACE centers may continue to operate as clinics following all applicable federal and state mandates relative to the COVID 19 public health emergency.

Each ADC, ADHC and PACE provider shall immediately notify its clients and families of the center closure.

If you have any questions, please contact OAAS or OCDD.

cc: OAAS Regional Offices
OCDD Local Governing Entities
OAAS Support Coordination Agencies
OCDD Support Coordination Agencies
Statistical Resources, Inc.
LDH Medicaid Program Support and Waivers

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Aging and Adult Services

MEMORANDUM **OAAS-P-20-025**

TO: **Adult Day Health Care (ADHC) Providers**

FROM: **Sherlyn Sullivan, OAAS Interim Assistant Secretary**

DATE: **June 1, 2020**

SUBJECT: **Updates to ADHC Provider Regarding Payments and Tracking Due to COVID-19 Emergency**

This memorandum is to update the Adult Day Health Care (ADHC) providers regarding payments related to the COVID-19 emergency and the continuation of their ADHC center closures.

Retroactive Payments:

OAAS and the Louisiana Department of Health (LDH) have authorized retroactive payments for ADHC providers at a 50% increase from the base rate for claims dated from 1/27/2020 through 3/23/2020. These claims will be automatically recycled by the LDH contractor, DXC. **ADHC providers will receive these payments on Tuesday, June 2, 2020**.

Payments and Tracking:

OAAS and LDH recognize that COVID-19 related closures and payments will impact provider cost reporting. Therefore, ADHC providers should track and maintain separate documentation of their expenses and revenues for the last quarter of this fiscal year (April 2020 – June 2020), as well as separate tracking and documentation for the first quarter of next fiscal year (July 2020 – September 2020). This is in addition to the records that ADHC providers are required to maintain in order to comply with their yearly cost reporting requirements in accordance with the ADHC Provider Manual and the ADHC Standards for Payments (LAC Title 50, Part XXI, Subpart 3).

Other COVID-Related Funds and Tracking:

Also, ADHC providers should retain appropriate documentation of any COVID-19 related funds that they receive through programs such as the U.S. Small Business Administration (SBA) Paycheck Protection Program (PPP), CARES Act Provider Relief Fund distributions or other State or Federal grant/loan programs. Documentation should include, at a minimum, the total amount of revenue received, the percentage of revenue retained and the amount of the loan principal and interest forgiven.

If you have any questions, please contact OAAS.ProviderRelations@la.gov.

c: OAAS Regional Offices
OAAS Support Coordination Agencies
Statistical Resources, Inc.
Medicaid Program Support and Waivers

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Aging and Adult Services

MEMORANDUM **OAAS-P-20-032**

TO: **Adult Day Health Care (ADHC) Providers**

FROM: **Sherlyn Sullivan, OAAS Interim Assistant Secretary** Sherlyn Sullivan

DATE: **August 7, 2020**

SUBJECT: **Updates to ADHC Providers Regarding Retainer Payments**

This memorandum is to update the Adult Day Health Care (ADHC) providers regarding retainer payments due to the continuation of ADHC center closures related to the COVID-19 emergency.

Retainer Payments:

In March 2020, the federal government approved the Louisiana Department of Health (LDH) to authorize retainer payments to ADHC providers at 75% of their current rate for 22 consecutive days (from 3/24/2020 – 4/22/2020). On April 1, 2020, billing units were released and ADHC providers began to bill for these claims.

In July 2020, the federal government approved LDH to authorize additional 25% retainer payments of their current rate to ADHC providers for the same time frame listed above (3/24/2020 – 4/22/2020). **Effective immediately, ADHC providers may bill for the additional 25% retainer payments. Details on how to bill are indicated on pages 2 & 3.**

The purpose of these retainer payments are for ADHCs to be able to keep staff on payroll, cover fixed expenses and re-open once the ADHCs are allowed to re-open their centers.

LDH retains the right to recoup all or a portion of retainer payments from ADHC providers who furlough or lay off staff or fail to re-open their ADHC centers.

How to Get Retainer Amounts in Order to Bill for Additional 25% Retainer Payment:

- If the ADHC provider's billing software reads the LaSRS Application Process Interface (API), they can download the updated retainer payment amounts into their billing software. ADHC providers must contact their software vendor if they have any questions.

- If the ADHC provider manually enters their billing claims, they can request a spreadsheet of the updated retainer payment amounts from Statistical Resources, Inc. (SRI).

  NOTE: If the ADHC provider received prior retainer payments this way, SRI will automatically generate and send the ADHC provider an updated spreadsheet.

How to Bill for These Additional Retainer Payments:

Billing for the remaining 25% of the ADHC retainer payments for the period of 3/24/2020 – 4/22/2020 will require the ADHC provider to file an adjustment claim for each retainer payment with DXC. On the adjustment claim, the ADHC provider will file for the new **FULL** amount (100%) of the retainer payment, indicating the Claim Control Number from the payment line on a previous Remittance Advice (RA) in which the partial payment had been made. If the adjustment claim is filed and meets payment criteria, DXC will calculate and pay the difference between the previously paid claim and the new adjusted claim.

- If the ADHC provider's billing software automatically can file adjustment claims, follow the ADHC provider's vendor's process. ADHC providers must contact their software vendor, if they have any questions.

- If ADHC providers manually enter their adjustment claims into their billing software, ADHC providers will need the Claim Control Number from the claim line in which they received the prior partial retainer payment.

  The Control Number for each retainer payment can be located in several different ways.

  - If ADHC providers receive paper RAs, the Control Number is the last column of the RA containing the partial retainer payment - the column is labeled Control Number.

  - If the ADHC provider's billing software downloads an electronic RA (also known as an "835"), the Control Number should be obtained by contacting the ADHC provider's billing software vendor and asking them how to get the Control Number.

- ADHC providers can also look up the Control Number in LaSRS. Under the menu item "MOLINA DATA", choose "Molina RAs". Click on the green "+" on the claim you want to adjust. The Control Number will be listed on the detail screen just after the label "ICN". If you have any questions about this process, please contact SRI's LaSRS technical support at 225.767.0501.

Our next ADHC Update meeting with ADHC providers is scheduled for Tuesday, August 11, 2020 at 1:00 p.m. where we will be addressing any questions regarding this memo.

If you have any questions, please contact OAAS.ProviderRelations@la.gov.

c: OAAS Regional Offices
OAAS Support Coordination Agencies
Statistical Resources, Inc.
Medicaid Program Support and Waivers

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health

HEALTHCARE FACILITY NOTICE/ORDER #2020-COVID19-ADC/ADHC/PACE-002

FOR IMMEDIATE RELEASE

TO: Adult Day Care (ADC) Providers
Adult Day Health Care (ADHC) Providers
PACE Providers

FROM: LDH Office of Public Health
Jimmy Guidry, M.D.
State Health Officer

RE: State Health Officer Order
(1) Reopening Procedures for ADC Providers
(2) Reopening Procedures for ADHC and PACE Providers

DATE: October 2, 2020

EFFECTIVE DATES: This Emergency Order shall be effective immediately, beginning 7:00 a.m. on Monday, October 5, 2020, and shall remain in effect until further notice from the State Health Officer.

RATIONALE AND LEGAL AUTHORITY:

On January 30, 2020, the International Health Regulations Emergency Committee of the World Health Organization declared the COVID-19 outbreak a "public health emergency of international concern" (PHEIC). On January 31, 2020, Health and Human Services Secretary Alex M. Azar II declared a public health emergency (PHE) for the United States, effective January 27, 2020. Pursuant to the Louisiana Health Emergency Powers Act, R.S. 29:760, *et seq.*, a state of public health emergency resulting from the outbreak of "coronavirus disease 2019" ("COVID-19") was declared to exist in the entire State of Louisiana by Proclamation Number 25 JBE 2020.

The COVID-19 outbreak in Louisiana continues. Measures are necessary to protect the health and safety of the public. The measures ordered herein are in line with the best

guidance and direction from the Centers for Medicare and Medicaid Services (CMS) and/or the U.S. Centers for Disease Control and Prevention (CDC).

The State Health Officer expressly finds that the measures ordered herein are necessary to help control and prevent further spread of COVID-19, a communicable, contagious, and infectious disease that represent a serious and imminent threat to the public health.

NOW THEREFORE, pursuant to the powers vested in me by L.R.S. 40:1 *et seq.*, particularly La. R.S. 40:4(A)(13) and La. R.S. 40:5(A)(2), I, Jimmy Guidry, M.D., State Health Officer, do hereby issue the following emergency order:

(1) All Adult Day Care (ADC) providers, all Adult Day Health Care (ADHC) providers, and all PACE providers in Louisiana, are eligible to re-open, effective Monday, October 5, 2020, at 7:00 a.m., provided that:

(a) The provider is located in a parish that has a COVID-19 parish positivity rate of 5% or lower, as indicated on the following website: https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg; **AND**

(b) The provider complies with the provisions of this State Health Officer Order.

(2) Any ADC provider that is eligible under Item 1 to re-open, is hereby mandated and directed to follow the provisions of the Louisiana Department of Health, entitled "Re-opening Adult Day Center Guidance", dated October 2, 2020, a copy of which is attached to this State Health Officer Order. Each ADC provider shall revise its current policy and procedure to reflect these new LDH provisions.

(3) Any ADC provider may impose stricter re-opening policies than mandated in the LDH "Re-opening Adult Day Center Guidance", if the facility chooses, provided that the facility have a policy and procedure in place to address such restrictions.

(4) Any ADHC provider or any PACE Provider that is eligible under Item 1 to re-open, is hereby mandated and directed to follow the provisions of the Louisiana Department of Health, entitled "Re-opening ADHC and PACE Center Guidance", dated October 2, 2020, a copy of which is attached to this State Health Officer Order. Each ADHC provider and PACE provider shall revise its current policy and procedure to reflect these new LDH provisions.

(5) Any ADHC provider or PACE provider may impose stricter re-opening policies than mandated in the LDH "Re-opening ADHC and PACE Center Guidance" if the facility chooses, provided that the facility have a policy and procedure in place to address such restrictions.

(6) If a parish's COVID-19 positivity rate increases above 5% after an ADC, ADHC, or PACE provider re-opens, the State Health Officer hereby reserves the right to issue a notice/order to any ADC, ADHC, or PACE provider to limit services at the provider's location or to close the provider's location for a specified period of

time. If there are two or more identified COVID-19 cases (staff or clients) at an ADC, ADHC, or PACE provider, the State Health Officer hereby reserves the right to issue a notice/order to any such provider to limit services at the provider's location or to close the provider's location for a specified period of time.

(7) This State Health Officer Order replaces and supersedes any previously issued State Health Officer orders/notices to ADC providers, ADHC providers, and PACE providers, regarding closure and re-opening procedures.

(8) This State Health Officer Order does not mandate that any ADC provider, ADHC provider, or PACE provider re-open. Any such facility that chooses to re-open shall contract the LDH Health Standards Section, as well as notify the applicable LDH program office (Office of Adult and Aging Services or Office for Citizens with Developmental Disabilities).

(9) This State Health Officer Order does not mandate that any client or participant return to an ADC, an ADHC, or PACE Center upon its re-opening.

(10) For questions concerning the "Re-opening Adult Day Center Guidance", please contact Paul Rhorer at (225) 342-0095 or Paul.Rhorer@La.Gov .

(11) For questions concerning the "Re-opening ADHC and PACE Center Guidance", please contact Allison Vuljoin at Allison.Vuljoin@La.Gov.

Dr. Courtney N. Phillips

Dr. Courtney N. Phillips
Secretary

Dr. Jimmy Guidry, MD

Dr. Jimmy Guidry, M.D.
State Health Officer

LOUISIANA
DEPARTMENT OF HEALTH
Office for Citizens with Developmental Disabilities

DATE: **October 2, 2020**

TO: **Adult Day Centers**

FROM: **Louisiana Department of Health**

RE: **Re-opening Adult Day Center Guidance**

Mark A. Ponthieux
Deputy Secretary
Louisiana Department of Health

Consistent with the Governor's Roadmap to Restarting Louisiana, the Louisiana Department of Health (LDH) is issuing guidance to Adult Day Centers (ADC) regarding re-opening once day services are allowed to reopen for participants.

Given that the risk for transmission of the virus causing COVID-19 is greater in group or congregate settings, and that some of the individuals served in Adult Day Centers have underlying conditions, the Louisiana Office of Public Health in collaboration with the Office for Citizens with Developmental Disabilities and LDH Health Standards Section offers the following guidance for operating upon re-opening.

This guidance will assist providers in determining how to re-open, how to staff, who will return to the center and when they will return. The decision to re-open a center may be based on the current phase in the center's city / parish and the center's ability to follow this guidance. Additionally, a person-centered approach should be taken for each individual receiving services to determine the most appropriate approach for service delivery. The goal is for participants to be served in the most appropriate setting; whether that be at home or the center.

Public Health Guidance

Category	Action Item
Group Size & Selection	• **Day Services** – maximum group size of 1:8 to allow for additional direct care staff as needed in each separate space. A separate space is defined by walls and doors. Everyone should be wearing a face mask or a face shield if unable to tolerate a face mask and observing social distancing requirements. • Assess participants to determine who will be served initially and during the initial phase-in. In general, participants who have fewer underlying health conditions that make them vulnerable to COVID 19, and those who are able to tolerate the use of a face mask/shield and who have the ability to follow the social distancing requirements are better candidates for facility-based participation in the initial phase. • The facility may serve more than one group at one time as long as each group has their own separate space. • Facility Based attendance is limited by the number of separate spaces available to serve participants (in groups of no more than 10 including the extras DSW staff) adhering to these guidelines and licensing standards.

	• Staff shall not mix among groups. Staff shall stay with one group for the entire time the participants are at the center. • Staff that do not routinely interact with participants, such as administrative or kitchen staff, are not included in the 10 person group maximum.
Social Distancing and Physical Standards	• Only static groupings will be allowed (same group for entire period, no mixing of groups). • Assign staff to groups for the entire period. • For example, a facility can accommodate a group of 8 participants and 1-2 staff for a morning. The group would stay in the same room the whole period. Participants will leave and room will be sanitized. Another group could come in the afternoon and the same staff could work with the afternoon group. Staff may not mix with two groups at the center at the same time. Or if it is more feasible to have specific groups on specific days and alternate the full day instead of half days. This will allow for those who travel farther to get to the center as well as time at the end of the day to do a thorough cleaning before the next day's group(s). • Groups while indoors should be separated by walls or partitions. • While outdoors, groups should maintain social distancing and should only be outside in their own group. • If there is a commonly used space among groups, such as a game area, the area should be cleaned between group usage. Program participants must enter and exit the building through the designated entry and exit points. Try staggering the times each group enter and exit the building to ensure social distancing. • In order for vendors to avoid contact with participants, facilities are encouraged to use curbside pick-up rather than allowing vendors into the center. • If family or caregiver drops someone at the facility, the family should not come inside but rather dropped off and met by staff. • To avoid over crowding at entry and exit points, stagger arrival and departure times of each group and if you have more than one entrance/exit, disperse the groups among the entrances/exits to maximize time. Allow extra time between groups when sharing rooms so that proper cleaning and disinfecting can be done. • Consider serving meals in the same room the group uses for the entire day. Also, to avoid crowds at the microwaves, is it possible to move the microwave to the room or if not enough, is it possible to stagger meal times and usage of the microwaves. • No family style dining. • Use disposable utensils. • If possible, assign restrooms to specific groups if more than one group is at the center at the same time.
Symptom Monitoring – Staff, Participants, Visitors, Volunteers and Vendors	• Staff must be instructed and required to screen themselves prior to leaving home for work. Screening includes symptom screening and taking temperature. See Mayo self-assessment tool in resource section. • Reinforce to staff the importance of staying home if they are ill or experience COVID-19 symptoms. • Educate and train staff on precautions for keeping themselves and families from contracting CV-19.

	• Educate participants and families on precautions for keeping themselves and families from contracting COVID-19. • Educate and train staff on how to assess an individual's health and how to take temperature. • Use screening questions to identify commonly associated symptoms of COVID-19 such as: - Cough, - Shortness of breath, - Chills, - Repeated shaking with chills, - Headache, - Sore throat, - New loss of taste or smell, and/or - Muscle pain. • If participants are being transported to the facility by staff, staff should screen the participant and take temperature using a no contact thermometer, prior to entering the vehicle. The participant should then use hand sanitizer and put on a mask. Families should be instructed to contact the staff if the participant is not feeling well or exhibiting symptoms. Staff may use health screening questions to assess participants by phone prior to transport. • Prior to entrance to the facility if participants are dropped off by family/caregiver, staff should meet the participant outside and take the temperature and provide hand sanitizer and have participant put on face covering. r. • Re-check staff and participant temperatures and perform symptom screening at mid-day. • An individual with a temperature of 100.4°F or above should get re-tested 5-10 minutes later. Anyone with a confirmed temperature of 100.4°F or above shall not be allowed in building. • If at any point on entry or during the day any individual is identified with temperature at or above 100.4°F, the center shall: - Isolate the individual from others in a safe location, - Arrange for participant to return home - Clean and disinfect surfaces in isolation area after participants have left for the day. *General* • Plan for individuals with symptoms which shall include verifying emergency contact information for caregivers to arrange pick/drop off at home and for routine follow-up on the individual's status. • Establish system to receive curbside delivery of supplies including the designation of staff to retrieve supplies. • Initial and periodic testing for COVID19 for ADC centers will not be provided by the state at this time.

Ensure Healthy Personal Hygiene	• **Practice proper hand hygiene. This is an important infection control measure. Wash hands regularly with soap and water for at least 20 seconds.** • Follow standard infection control precautions per training and policies and procedures. • Participants and staff, must wash or sanitize their hands at arrival, after engaging with each person where touching is involved, after touching common touch points such as door knobs, after restroom after touching any commonly touched area such as microwaves, before and after eating, and at exit. • Participants shall wear masks/face shields at the center (as appropriate and according to clinical conditions and cognitive status). • Cloth masks are recommended by the CDC. • Cloth masks must be washed daily by the provider. • Disposable masks are acceptable and can be used by one person for an entire day before being discarded. • Consider using pre-packaged snacks, meals and condiments. No self-serve drinks and snacks. • Consider providing hygiene kits to participants including mask and sanitizer to use at home.
Transportation	• It is recommended that the driver NOT be a person at high-risk for contracting COVID-19. • Encourage participant family/caregivers drop-off and pick-up as alternative to traveling on the vehicle. • The vehicle must be disinfected prior to starting the day, in between trips and at the end of the day. • Driver should wear face mask and wash hands before shift and as needed throughout the day. • The facility should consider assigning staff to accompany driver to assist with taking temperature, masking and social distancing along the route. • A supply of hand sanitizer must be in each vehicle at all times for use by participants and drivers. • After the driver/staff takes the participant's temperature, the participant must sanitize hands and put on mask before boarding the bus. • Driver/staff should assist with hand sanitizing and applying mask on participant, as needed. • Driver/staff should use sanitizer after each participant is boarded onto the vehicle. • To increase airflow, windows should be open to the maximum extent possible. • High-touch surfaces are cleaned after each group's use. • Develop a seating plan that ensures social distancing on each vehicle: - Vehicle shall not exceed 50% capacity, including staff - Masks shall be worn at all times on the vehicle - Participants are to ride one per seat with every other seat empty or configure where social distancing is practiced as this may be different for each vehicle.
Intensify Environmental	• Shared indoor facilities are cleaned after every group's use.

Cleaning and Disinfectant Efforts	• Evaluate center to determine what kinds of surfaces and materials comprise each area. • Consult EPA guidance for acceptable disinfectants (see resource link below). • Consult the CDC for guidance on establishing cleaning and disinfecting protocol for various surface types and materials (see resource link below). • High touch surfaces must be cleaned multiple times per day including bathrooms (door handles, soap dispensers, faucets, hand drying areas, light switches, doors, benches, chairs, kitchen countertops, carts, trays and other identified surfaces. • Minimize sharing of materials between participants. • To protect their skin, staff should wear gloves when performing cleaning activities. Gloves should be changed often and when moving from one activity to another. • Consider the use of electrostatic sprayers to disinfect transportation vehicles and the center.
Ventilation	• Ensure that ventilation systems operate properly and increase circulation of outdoor air as much as possible, for example, by opening windows and doors. • Perform activities outside as much as possible • Do not open windows and doors if doing so poses a safety or health risk to persons attending the center (e.g., risk of falling, triggering of asthma symptoms).

PPE Required to Re-open	• Necessary PPE:
	  • Cloth and/or disposable masks for staff and participants.
	  • Wipes
	  • Antibacterial soap and hand sanitizer
	  • EPA approved disinfectant (see link in resources), and
	  • Gloves for use when touching participant.
	• PPE must be provided by the center.
	• Soap and water should be used when available as hand sanitizer is not a substitute to washing with soap and water. However, hand sanitizer must be used when soap and water is not available. The sanitizer must contain at least 60% and not more than 80% alcohol.

Administrative – Participant Services	• Develop re-opening plan and adhere to it. The plan must include actions to be taken if any individual or staff presents with symptoms and/or COVID-19 positive test result. • Re-admission to the facilities may have to be continually reassessed as space in the facility allows and individual participant health status and exposures change. • Elicit and incorporate input from staff representing all aspects of program operations into your re-opening plan, e.g. activities, food service, transportation, etc. • Assess how space will be configured to meet social distancing requirements and determine capacity limits; how many static groupings can the facility host? • Assess all rooms in the center to determine how they will be used, who will use them, how to set-up, and clean:

	- Day room, - Kitchen/food service, - Reception areas/entryways, - Staff offices and workspaces - Staff break rooms; and - Conference rooms. • Consider staging proposed layout for each designated area. • Consider marking the floor with location of furniture and keep furniture on markings to maintain social distancing. • Consider using signage that everyone understands to encourage social distancing. • Remove furniture that compromises social distancing, such as extra chairs, chairs in staff break room to prevent staff form sitting too close to one another. • In addition to wearing masks, staff must practice social distancing at all times, including time spent in offices and break rooms. • Have staff take breaks outside or in car, as opposed to break rooms which may easily become congested and cannot accommodate all staff without compromising social distancing. • Assess availability of adequate stock of appropriate supplies/PPE and identify supply sources. • Assess availability of staff and begin development of staffing plan.
Communication	• It is imperative that participants, families and staff receive frequent updates regarding re-opening. • Communication needs to be provided routinely even when news is limited. • Must communicate to caregivers: the importance of keeping participants home when they are sick; that masks should be worn in public places to the extent possible to minimize exposure; steps being taken by the facility to ensure the health and safety of participants; and other important information related to limiting COVID-19 exposure. • Display COVID-19 informational signs that everyone understands in highly visible locations that promote everyday protective measures and describe how to stop the spread of germs, such as properly washing hands and properly wearing a mask/face shield. • Place signs at entry stating that masks/shields must be worn inside the facility. • Frequent prompts to everyone on wearing masks and washing hands/using hand sanitizer to keep everyone on track throughout the day.

General Business Guidance

Staffing	• Stay in touch with staff and know their plans. • Keep them informed even when they're not working. • Identify staffing needs as operations are resumed.

	• Plan to scale up to full capacity in phases.. • Recruit as needed in advance of resumption of services. • Use time to evaluate staff and develop needed competencies for new policies, procedures or business opportunities. • Consider a paid time off (PTO) policy that prevents staff from coming in sick, e.g. 80 hours (PTO) if staff member or family are sick due to COVID-19.
Administrative – General Business Operations	• Update infection control, HR and other policies and procedures implemented as a result of CV19. Continue to follow standard infection control policies and procedures. • Update emergency preparedness plan, as needed. • Train staff and monitor for proper implementation, as needed. • Daily schedule/hours of operation may initially be reduced and increased over time. • Unique opportunity to reassess business processes, models, and goals, including current and projected revenue streams. • Review basic business processes – billing, scheduling, building maintenance, etc. for opportunities to improve efficiency when things start back up. • Explore opportunities to add services on a permanent basis. • Have a plan for response should a participant or staff demonstrate symptoms of COVID-19 and/or test positive for COVID-19; the plan shall comply with the provisions set forth in the LDH document entitled "COVID-19 Contact Tracing in ADC, ADHC, PACE Facilities" issued October 2, 2020, a copy of which is attached to this guidance.
Licensing	• If the provider cannot resume operations, they are to contact Health Standards and each individual situation will be evaluated. Staff needs to look at regulations to see what is allowed. • Health Standards will not be performing onsite inspection of each center prior to re-opening. • Complaints or routine surveys will be performed as required. • Every provider is expected to have appropriate processes in place to minimize exposure to the virus.
Technology	• Internet connection/email accounts – may be a good time to upgrade if technology does not have ideal capability to meet needs. • Research remote meeting applications, for example: Zoom, Live Meeting, etc.

Intellectual / Developmental Disabilities Services Guidance

Waiver Services Available	• **Individual Supported Employment** • **Group Supported Employment** • Upon approval of Appendix K from CMS ○ **Day Habilitation** (Community Participation) in a Ratio 1:3 or 1:1

	○ **Prevocational Services** (Discovery) in a Ratio of 1:3 or 1:1 ○ **Virtual Day Habilitation** (Ratio 1:8) ○ **Virtual Prevocational** (Ratio 1:8) ○ **Virtual Individual Supported Employment Follow Along** (1:1) • **Facility Based services, Day Habilitation and/or Prevocational Services** must follow all guidelines noted above. It is recommended that each agency utilizes the services available in a manner that will allow for individuals to have a meaningful day. For example, there may be individuals who are not ready to return to the facility but might be interested in doing small community group or virtual day hab. Or there may be people who do not want to go out in the community or facility but could do virtual services. Please discuss the options with each participant so they can make an informed choice of what option is best for them. • Keep in mind that by utilizing more services in the community, and offering true individual choice, your agency is moving closer to compliance with the HCBS Settings Rule. • Also,
Individual and Group Supported Employment	• Individual and Group Supported Employment have remained available during the pandemic for individuals without underlying conditions and in small groups. • On June 15, 2020, a memo and guidance were released to providers regarding these services. • **Upon approval from CMS, Virtual Individual Supported Employment Follow Along** will be able to be provided 1:1 and can be used to assist someone who is working in an independent job but may need follow up and because of the pandemic you are not able to go on the job to assist the participant. You can utilize the telephone or such methods as FaceTime to provide services to the participant in the form of guidance or instruction or to facilitate a meeting with the participant's employer.
Day Habilitation	• Upon approval from CMS, Day Habilitation can be delivered virtually in the Supports Waiver, NOW and the ROW. • **Virtual Day Habilitation Services** will be available in a ratio of 1:8 and services can be delivered virtually using such programs as Zoom or Google Classroom. This service cannot be delivered at the same time as other waiver services. • Upon approval from CMS, Day Habilitation will be allowed to be delivered in the community in a ratio of 1:3 in the Supports Waiver, NOW and ROW. • This service is designed to allow staff to take a group of no more than 3 participants in the community to do activities that are available. • This service can be used to do such things as volunteering or some type of 'service work' in the community or it can be recreational in nature. • The activities should be based on the individual's interests and discussions with the individual's should take place to plan the activities. • Transportation can be billed for each participant who is in the ROW or NOW. This can be billed 2 times per day; a trip to the activity and a trip home from the activity.

	• This service can be used as a wraparound service for participants who utilize other 'work' services or as a stand-alone service.
Prevocational Services	• Upon approval from CMS, Prevocational Services can be delivered virtually in the Supports Waiver, NOW and the ROW. • **Virtual Prevocational Services** will be available in a ratio of 1:8 and services can be delivered virtually using such programs as Zoom or Google Classroom. This service can be used to do 'Discovery' type activities and should be used **ONLY** for participants who want to work. This service cannot be delivered at the same time as other waiver services. • Upon approval from CMS, Prevocational Services will be allowed to be delivered in the community in a ratio of 1:3 in the Supports Waiver, NOW and ROW. • This service is designed to allow staff to take a group of no more than 3 participants in the community to do activities that are available to promote 'discovery'. • This service can be used to do 'Discovery' type activities and should be used only for **participants who want to work**.

Resources:

Louisiana Department of Health

http://www.ldh.la.gov/

Plain Language pamphlet on COVID19

https://selfadvocacyinfo.org/wp-content/uploads/2020/03/Plain-Language-Information-on-Coronavirus.pdf

Coronavirus Tips for Staying Healthy/Self Determination

https://www.youtube.com/watch?v=V7Yl-BesvDw&feature=youtu.be

Mayo Clinic Self-Assessment Tool

https://www.mayoclinic.org/covid-19-self-assessment-tool

Wheelchair and AT Users: Precautions for COVID19

https://www.aahd.us/wp-content/uploads/2020/04/WC_COVID-19-Precautions.pdf

Federal Emergency Management Agency (FEMA) Fact Sheet

https://www.fema.gov/news-release/2020/04/30/planning-considerations-organizations-reconstituting-operations-during-covid

Community Transportation Association of America
https://ctaa.org/covid-19-resources/

Centers for Disease Control

www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html

Cleaning your facility: https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html

Environmental Protection Agency

Approved disinfectants: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2

Occupational Safety and Health Administration

www.osha.gov/SLTC/covid-19

Office of the State Fire Marshal

http://sfm.dps.louisiana.gov/

U.S Department of Health and Human Services, Office of Civil Rights FAQ on Telehealth and HIPAA during COVID-19 Nationwide Public Health Emergency

https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf

Resources for technology, providing quality supports, virtual services, working during the pandemic

https://covid19.communityinclusion.org/

Online Resources for Virtual Day Habilitation

Virtual Tours of museums, zoos, aquariums, theme parks

https://www.goodhousekeeping.com/life/travel/a31784720/best-virtual-tours/

Lunch Doodles with Mo Willems

https://www.youtube.com/watch?v=fh5QFhUz43U&feature=youtu.be

Free online art classes

https://www.thoughtco.com/free-online-drawing-classes-1098200

https://www.youtube.com/watch?v=RmzjCPQv3y8

Online classes for self-advocacy and business classes

https://celebrateedu.org/online-classes/

https://covid19.communityinclusion.org/pdf/CLE_issue10_V2_D2.pdf

FUNDING RESOURCES:

https://www.everyoneon.org/

https://www.allconnect.com/blog/low-income-internet-guide

https://www.techgoeshome.org/

https://www.ssa.gov/disabilityresearch/wi/generalinfo.htm

https://www.at3center.net/

https://www.cabletv.com/blog/low-income-internet

Note: Guidance is subject to change. Ensure that the most recent version is being used.

LOUISIANA
DEPARTMENT OF HEALTH
Office for Citizens with Developmental Disabilities

Mark A. Reed
Deputy Secretary
Louisiana Department of Health

DATE: October 2, 2020

TO: **Adult Day Health Care Centers**
PACE Centers

FROM: **Louisiana Department of Health**

RE: **Re-opening ADHC and PACE Center Guidance**

Consistent with the Governor's Roadmap to Restarting Louisiana, the Louisiana Department of Health is issuing guidance to Adult Day Health Care (ADHC) and Program for All-inclusive Care for the Elderly (PACE) centers. This guidance is relative to operating centers once day services are allowed to reopen for participants.

Given that the risk for transmission of the virus causing COVID-19 is greater in group or congregate settings, and that the population served in PACE and ADHC is at higher risk for adverse outcomes, the Louisiana Office of Public Health in collaboration with the Office of Aging and Adult Services and LDH Health Standards Section offers the following guidance for operating upon re-opening.

This guidance is based on current medical knowledge of how COVID-19 is transmitted, which is primarily through close physical contact during which aerosol particles might be emitted, and due to touching shared surface or objects.

This guidance will assist providers in determining how to re-open, how to staff, who will return to the center and when they will return. The Department's goal is for participants to be served in the most appropriate setting; whether that be at home or the center. Contact Allison Vuljoin at Allison.Vuljoin@la.gov with questions.

Public Health Guidance

Category	Action Item
Group Size & Selection	- **Day Services** – maximum group size of 10 including both direct care staff and participants in each separate space (space separated by wall or partition), wearing masks (participants as able), and observing social distancing requirements. - Assess participants to determine who will be served initially and during phase-in. In general, participants who are younger or have fewer underlying health conditions that make them vulnerable to COVID 19, and those with cognitive capacity to understand masking and social distancing, are better candidates for center participation in initial phases. - The center may serve more than one group at one time, as long as each group has their own separate space.

	- Center attendance is limited by the number of separate spaces available to serve participants (in groups of 10 including staff) adhering to these guidelines and licensing standards. - Staff shall not mix among groups. Staff shall stay with one group for the entire time the participants are at the center. - Staff that do not routinely interact with participants, such as administrative or kitchen staff, are not included in the 10 person group maximum. - **Transportation** – Buses may transport up to 50% capacity, wearing masks (participants as able) and seated to maintain social distancing.
Social Distancing and Physical Standards	- Only static groupings will be allowed (same group for entire period, no mixing of groups). - Assign staff to groups for the entire period to prevent staff working with more than one group. - For example, a center can accommodate a group of 8 participants and 1-2 staff for a morning. The group would stay in the same room the whole period. Participants will leave and room will be sanitized. Another group could come in the afternoon and the same staff could work with the afternoon group. Staff may not mix with two groups at the center at the same time. - Groups convened indoors should be separated by walls or partitions. - Groups do not convene in indoor spaces unless the spaces are cleaned before and after the group's use. - Program participants must enter and exit the building through the designated entry and exit points. - In order for vendors to avoid contact with participants, centers are encouraged to use curbside pick-up rather than allowing vendors into the center. - Avoid crowding at entry and exit points: observe limits on maximum group sizes and physical distance recommendations; have a plan/protocol if the space becomes overcrowded. - Allow extra time between groups when sharing rooms so that proper cleaning and disinfecting can be done. - Consider serving meals in the room the group uses entire day. - No family style dining. - Use disposable utensils. - If possible, assign restrooms to specific groups if more than one group is at the center at the same time.
Symptom Monitoring – Staff, Participants,	- Staff must be instructed and required to screen themselves prior to leaving home for work. Screening includes symptom screening and taking temperature. See Mayo self-assessment tool in resource section.

Visitors, Volunteers and Vendors	- Reinforce to staff the importance of staying home if they are ill or experience COVID-19 symptoms. - Educate and train staff on precautions for keeping themselves and families from contracting CV-19. - Educate participants and families on precautions for keeping themselves and families from contracting COVID-19. - Educate and train staff on how to assess an individual's health and how to take temperature. - Use screening questions to identify commonly associated symptoms of COVID-19 such as: - Cough, - Shortness of breath, - Chills, - Repeated shaking with chills, - Headache, - Sore throat, - New loss of taste or smell, and/or - Muscle pain. - Center staff may use health screening questions to assess participants by phone prior to transport. - All entrants shall have temperature taken, ideally with a no contact thermometer. - Re-check staff and participant temperatures and perform symptom screening at mid-day. - An individual with a temperature of 100.4°F or above should get re-screened 5-10 minutes later. - Anyone with a confirmed temperature of 100.4°F or above shall not be allowed in building. - If at any point on entry or during the day any individual is identified with temperature at or above 100.4°F, the center shall: - Isolate the individual from others in a safe location, - Arrange for participant to return home - Clean and disinfect surfaces in isolation area after participants have left for the day. *General* - Plan for individuals with symptoms which shall include verifying emergency contact information for caregivers to arrange pick/drop off at home and for routine follow-up on the individual's status. - Establish system to receive curbside delivery of supplies including the designation of staff to retrieve supplies.

	- Initial and periodic testing for COVID19 for ADHC and PACE centers will not be provided by the state at this time.
Ensure Healthy Personal Hygiene	- **Practice proper hand hygiene. This is an important infection control measure. Wash hands regularly with soap and water for at least 20 seconds.** - Follow standard infection control precautions per training and policies and procedures. - Participants and staff, must wash or sanitize their hands at arrival, at least every two hours, before and after eating, and at exit. - Participants shall wear masks at the center (as appropriate and according to clinical conditions and cognitive status).. - Cloth masks are recommended by the CDC. - Cloth masks must be washed daily by the provider - Disposable masks are acceptable and can be used by one person for an entire day before being discarded. - Consider using pre-packaged snacks, meals and condiments. No self-serve drinks and snacks. - Consider providing hygiene kits to participants including mask and sanitizer to use at home.

Transportation	- It is recommended that the driver NOT be a person at high-risk for contracting COVID-19.
	- Encourage participant family/caregivers drop-off and pick-up as alternative to traveling on the center's bus/van.
	- Bus must be disinfected prior to starting the day, in between trips and at the end of the day.
	- Driver should wear face mask and wash hands before shift and as needed throughout the day.
	- A supply of hand sanitizer must be in each van at all times for use by participants and drivers.
	- Driver should use sanitizer after touching a participant, before and after a participant boards the bus and when hands get soiled.
	- Participant must sanitize hands and put on mask before boarding the bus.
	- Driver to assist with hand sanitizing and applying mask on participant, as needed.
	- Develop a seating plan that ensures social distancing:
	  - Bus shall not exceed 50% capacity, including staff
	  - Masks shall be worn at all times on the bus/van.

	- Participants are to ride one per seat with every other seat empty, or configured where social distancing is practiced as this may be different for each vehicle. - To increase airflow, windows should be open to the maximum extent possible. - High-touch surfaces are cleaned after each group's use. - Center should consider assigning staff to accompany driver to assist with masking and social distancing along the route.
Intensify Environmental Cleaning and Disinfectant Efforts	- Shared indoor facilities are cleaned after every group's use. - Evaluate center to determine what kinds of surfaces and materials comprise each area. - Consult EPA guidance for acceptable disinfectants (see resource link below). - Consult the CDC for guidance on establishing cleaning and disinfecting protocol for various surface types and materials (see resource link below). - High touch surfaces must be cleaned multiple times per day including bathrooms (door handles, soap dispensers, faucets, hand drying areas, light switches, doors, benches, chairs, kitchen countertops, carts, trays and other identified surfaces. Minimize sharing of materials between participants. - To protect their skin, staff should wear gloves when performing cleaning activities. Gloves should be changed often and when moving from one activity to another. - Minimize sharing of materials between participants. - Consider the use of electrostatic sprayers to disinfect transportation vehicles and the center.
Ventilation	- Ensure that ventilation systems operate properly and increase circulation of outdoor air as much as possible, for example, by opening windows and doors. - Perform activities outside as much as possible - Do not open windows and doors if doing so poses a safety or health risk to persons attending the center (e.g., risk of falling, triggering of asthma symptoms).
PPE Required to Re-open	- Necessary PPE: -Cloth and/or disposable masks for staff and participants. CDC recommends cloth masks. -Wipes -Antibacterial soap and hand sanitizer -EPA approved disinfectant (see link in resources), and -Gloves for use when touching participant. - PPE must be provided by the center.

	- Soap and water should be used when available as hand sanitizer is not a substitute to washing with soap and water. However, hand sanitizer must be used when soap and water is not available. The sanitizer must contain at least 60% and not more than 80% alcohol.
Administrative – Participant Services	- Develop re-opening plan and adhere to it. - Assess participants to determine who will be served initially and during phase-in. In general, participants who are younger or have fewer underlying health conditions that make them vulnerable to COVID 19, and those with cognitive capacity to understand masking and social distancing, are better candidates for center participation in initial phases. - Re-admission to the centers may have to be continually reassessed as space in the center allows and individual participant health status and exposures change. - Elicit and incorporate input from staff representing all aspects of program operations into your re-opening plan, e.g. activities, food service, transportation, etc. - Assess how space will be configured to meet social distancing requirements and determine capacity limits; how many static groupings can center host? - Consider need for multiple shifts, extended hours, opening on weekends. - Assess all rooms in the center to determine how they will be used, who will use them, how to set-up, and clean: - Day room, - Kitchen/food service, - Quiet rooms, - Reception areas/entryways, - Staff offices and workspaces - Staff break rooms; and - Conference rooms. - Consider staging proposed layout for each designated area. - Consider marking the floor with location of furniture and keep furniture on markings to maintain social distancing. - Consider using signage to encourage social distancing. - Remove furniture that compromises social distancing, e.g. extra chairs, chairs in staff break room to prevent staff from sitting too close to one another. - In addition to wearing masks, staff must practice social distancing at all times, including time spent in offices and break-rooms. - Have staff take breaks outside or in car, as opposed to break rooms which may easily become congested and cannot accommodate all staff without compromising social distancing.

	- Assess availability of adequate stock of appropriate supplies/PPE and identify supply sources. - Assess availability of staff and begin development of staffing plan.
Communication	- Imperative that participants, families and staff receive frequent updates regarding re-opening. - Communication needs to be provided routinely even when news is limited. - Must communicate to caregivers: the importance of keeping participants home when they are sick; that masks should be worn in public places to the extent possible to minimize exposure; steps being taken by the center to ensure the health and safety of participants; and other important information related to limiting COVID-19 exposure. - Display COVID-19 informational signs in highly visible locations that promote everyday protective measures and describe how to stop the spread of germs, such as properly washing hands and property wearing a mask. - Place signs at entry stating that masks must be worn inside the center. - Frequent prompts to everyone on wearing masks and washing hands/using hand sanitizer to keep everyone on track throughout the day.

General Business Guidance

Staffing	- Stay in touch with staff and know their plans. - Keep them informed even when they're not working. - Identify staffing needs as operations are resumed. - Plan to scale up to full capacity in phases. - Recruit as needed in advance of resumption of services. - Use time to evaluate staff and develop needed competencies for new policies, procedures or business opportunities. - Consider a paid time off (PTO) policy that prevents staff from coming in sick, e.g. 80 hours (PTO) if staff member or family are sick due to COVID-19. - Consider system for staff to "punch in" remotely. - Consider using a COVID-19 screening tool App so that staff can submit answers to screening questions using their phones; email is sent that staff person passed screen; supervisors can get reports on staff. This is a new resource, so research must be done if considering this option. -

Administrative – General Business Operations	- Update infection control, HR and other policies and procedures implemented as a result of CV19. Continue to follow standard infection control policies and procedures. - Update emergency preparedness plan, as needed. - Train staff and monitor for proper implementation, as needed. - Explore and pilot options to appropriately serve cognitively impaired participants while still meeting social distancing requirements – smaller groups, additional supervision, types of activities, how to serve meals, etc. - Daily schedule/hours of operation may initially be reduced and increased over time. - Unique opportunity to reassess business processes, models, and goals, including current and projected revenue streams. - Review basic business processes – billing, scheduling, building maintenance, etc. for opportunities to improve efficiency when things start back up. - Opportunity to add services on a permanent basis. - Have a plan for response should a participant or staff demonstrate symptoms of COVID-19 and/or test positive for COVID-19; the plan shall comply with the provisions set forth in the LDH document entitled "COVID-19 Contact Tracing in ADC, ADHC, PACE Facilities" issued October 2, 2020, a copy of which is attached to this guidance.
Licensing	- If the provider cannot resume operations, they are to contact Health Standards and each individual situation will be evaluated. Staff needs to look at regulations to see what is allowed. - Health Standards will not be performing onsite inspection of each center prior to re-opening. - Complaints or routine surveys will performed as required. - Every provider is expected to have appropriate processes in place to minimize exposure to the virus.
Technology	- Internet connection/email accounts – may be a good time to upgrade if technology does not have ideal capability to meet needs. - Research remote meeting applications, for example: Zoom, Live Meeting, etc. - Recognizing that participant's access to technology may be limited, use HIPAA compliant platforms when participant can use for face-to-face interaction with participant, when necessary. - Applications such as Apple FaceTime, Facebook Messenger, WhatsApp, Zoom and Skype meet HIPAA requirements. Because they are "non-public facing" remote communication, these applications allow only the intended parties to participate in the communication. As a result, these applications meet HIPAA requirements and are allowable for video-communication with

	participants. The U.S. Department of Health and Human Services has issued guidance and a list of authorized applications. See resources on the last page for link.

Resources:

Louisiana Department of Health

http://www.ldh.la.gov/

OAAS FAQ

http://ldh.la.gov/assets/docs/OAAS/ProviderMemos/OAAS-P-20-011-COVID-19-FAQ.pdf

Plain Language pamphlet on COVID19

https://selfadvocacyinfo.org/wp-content/uploads/2020/03/Plain-Language-Information-on-Coronavirus.pdf

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Community Transportation Association of America
https://ctaa.org/covid-19-resources/

Centers for Disease Control

www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html

Cleaning your facility: https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html

Environmental Protection Agency

Approved disinfectants: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2

Occupational Safety and Health Administration

www.osha.gov/SLTC/covid-19

Office of the State Fire Marshal

http://sfm.dps.louisiana.gov/

U.S Department of Health and Human Services, Office of Civil Rights FAQ on Telehealth and HIPAA during COVID-19 Nationwide Public Health Emergency

https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf

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LOUISIANA DEPARTMENT OF HEALTH

Issued 10/02/2020

COVID-19 Contact Tracing in ADC, ADHC, PACE Facilities

When a COVID-19 infection is identified among a participant or staff member in an Adult Day Care Center (ADC), Adult Day Health Center (ADHC) or PACE facility, it is critical to conduct immediate contact tracing and identify all participants and staff members who have been in close contact with this person. This should be done individually for each person identified with COVID-19 in the facility, including laboratory confirmed and suspect cases (see step 1 below).

Contact tracing slows the spread of COVID-19 by identifying and notifying people that they may have been exposed, asking them to monitor their health, and asking them to self-quarantine. Timely and thorough contact tracing can effectively interrupt the chain of disease transmission and is an important public health intervention to prevent or contain an outbreak. By keeping those that may have been exposed to COVID-19 away from others, further transmission may be prevented.

This document outlines the actions that shall be taken when a person with COVID-19 is identified in a ADC, ADHC, or PACE facility: 1. Steps to identify COVID-19 infections and report to LDH; 2. Steps to identify and notify close contacts; and 3. Steps to conduct cleaning and disinfection.

1. **Steps to identify COVID-19 infections and report to LDH**
   - **Identify a person with COVID-19 infection.** A person with COVID-19 infection that would require reporting to LDH and conducting contact tracing is defined as:
     - Laboratory-Confirmed Case: someone who receives a positive COVID-19 viral test result, including molecular/PCR or antigen tests, whether rapid or send-out. Antibody tests indicate past exposure and *should not* be used to diagnose current infection or to initiate contact tracing.

       OR
     - Suspect Case: someone who is clinically diagnosed with COVID-19 or meets the following clinical criteria:
       - At least one of the following major COVID-19 symptoms: cough, shortness of breath, difficulty breathing, or new changes in sense of smell or taste

         OR
       - At least two of the following minor COVID-19 symptoms: fever (measured or subjective), chills, rigors, muscle ache/myalgia, headache, sore throat, nausea/vomiting, diarrhea, congestion/runny nose or fatigue

         AND
       - No alternative more likely diagnosis
       - If a suspect case subsequently tests negative by molecular/PCR test, they can return to the facility when they are symptom-free for 24 hours and any close contacts that have been quarantined may return to the facility. If a suspect case tests negative by antigen test, they should continue to follow recommendations for suspect cases as antigen tests are not as sensitive as molecular/PCR tests and may result in a false negative.
   - If a person has symptoms but does not meet the symptom criteria for suspect cases above, they should be sent home and not return to the facility until they are symptom-free for 24 hours. Contact tracing does not need to be done for these individuals.

- ☐ **Isolate and send the person home immediately.** They should not return to the facility until the following "end of self-isolation criteria" are met:
  - ☐ For a person with ANY symptom(s):
    - ☐ At least 10 days have passed since symptoms first appeared **AND**
    - ☐ At least 24 hours have passed since the resolution of fever without the use of fever reducing medications **AND**
    - ☐ Other symptoms (e.g., cough, shortness of breath) have improved.
  - ☐ For a person who remained asymptomatic (i.e., never had any symptoms):
    - ☐ At least 10 days have passed since positive test collection date.
- ☐ **Report all confirmed and suspect cases to Louisiana Office of Public Health (OPH).** Regional OPH Offices are available to provide consultation and recommendations upon request.

2. Steps to identify and notify close contacts of persons identified as having COVID-19 infection

- ☐ **Determine who has been in close contact with suspected and confirmed COVID-19 cases in the facility during their infectious period.**
  - ☐ Close contact is defined as
    - ☐ being within 6 feet of an infected person for at least 15 minutes **OR**
    - ☐ having direct contact with an infected person, including touching, hugging, kissing, or sharing eating or drinking utensils; or if an infected person sneezed, coughed, or somehow got respiratory droplets on another person
  - ☐ The infectious period includes the 48 hours before the day the person became sick (or the 48 hours before specimen collection if asymptomatic) until the person was isolated.
  - ☐ Use of face coverings and plastic dividers are not considered in determining close contacts, though they do reduce the risk of transmission.
  - ☐ Identify close contacts that may have occurred during any time or place the person was at the facility during the infectious period, including in the restrooms.
  - ☐ If a close contact is identified **who was diagnosed with COVID-19** by a positive molecular/PCR test (not an antigen or antibody test) within the last 90 days and
    - ☐ they do not have symptoms, they do not need to quarantine unless symptoms develop.
    - ☐ they do have symptoms, they should self-quarantine immediately for 14 days and consult with a medical provider to determine if they may have been re-infected with COVID-19 or if symptoms are caused by something else.
- ☐ **Notify close contacts of the need to quarantine.**
  - ☐ Notify all close contacts of suspect and confirmed cases that they have been identified as having been exposed to someone who is or may be ill with COVID-19 and will need to quarantine and stay out of the facility for 14 days from the last date they were exposed. A template letter can be provided to the facility by the Office of Public Health.
  - ☐ Encourage the close contacts to call the Louisiana Department of Public Health Contact Tracers at 1-877-766-2130.

- **Ensure close contacts remain out of the facility until the end of their quarantine period.**
  - Close contacts should not return to the facility until 14 days have passed from the last date they were exposed.
  - If a close contact in quarantine becomes symptomatic and tests positive, they would be considered a case as of the day their symptoms began and would need to follow "end of self-isolation criteria" above to return to the facility.
  - If a close contact in quarantine becomes symptomatic but is not tested, they would be considered a case as of the day their symptoms began and would need to follow "end of self-isolation criteria" above to return to the facility or 14 day quarantine, whichever is longer.
  - If a close contact in quarantine tests positive but does not develop symptoms, they would be considered a case as of the day their test was collected and would need to follow "end of self-isolation" criteria above to return to the facility.
  - If a close contact tests negative during their quarantine period, they should remain in quarantine for the duration of the 14 days and monitor for the development of symptoms at any time during the quarantine period.
  - If a suspect case tests negative by molecular/PCR test, any quarantined close contacts of that suspect case may return to the facility.
- **OPH recommends facilities consider notifying all participants and staff that there was a person with COVID-19 infection identified and close contacts have been notified.**

3. **Steps to conduct cleaning and disinfection according to CDC guidance**

- Close off areas used by the persons with COVID-19 and wait as long as practical before beginning cleaning and disinfection to minimize potential for exposure to respiratory droplets
  - Open outside doors and windows to increase air circulation in the area.
  - If possible, wait up to 24 hours before beginning cleaning and disinfection.
- Clean and disinfect all areas (e.g., offices, bathrooms, and common areas) used by the person(s) with COVID-19, focusing especially on frequently touched surfaces
  - Surfaces should be cleaned using soap (or a detergent) and water prior to disinfection.
  - For disinfection, most common EPA-registered household disinfectants should be effective against the virus that causes COVID-19. Check EPA's list of disinfection products.
- See full CDC Cleaning, Disinfection, and Hand Hygiene in Schools Guidance.

Document Updates:

Date	Update
10/02/2020	Initial Issuance

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Aging and Adult Services

MEMORANDUM **OAAS-P-19-010**

TO: OAAS Adult Day Health Care Providers

FROM: Tara A. LeBlanc
OAAS Assistant Secretary

DATE: June 17, 2019

SUBJECT: New Rate for ADHC Service

As a result of the budget legislation passed in the 2019 Regular Legislative Session, the Louisiana Department of Health (LDH) Office of Aging and Adult Services (OAAS) is funded and authorized to rebase rates paid to Adult Day Health Care providers for the following Medicaid service type:

SERVICE:	PROCEDURE CODE:	NEW RATE:	EFFECTIVE DATE:
Adult Day Health Care (ADHC)	S5100	$2.56 per 15 minutes plus provider specific transportation rate	01/01/2019

Effective June 21, 2019, claims for dates of service on or after January 1, 2019 should be billed at the new rate listed above.

Any claims billed prior to June 21, 2019 with dates of service on or after January 1, 2019 will be recycled. We anticipate that recycles will occur July 9th and 16th, and that payments for the difference in the rates will be issued on those July check writes.

Providers may also access the updated service procedure codes/rates by going to the following link:
https://www.lamedicaid.com/provweb1/fee_schedules/ADHC_Billing_Codes_Current.pdf

ADHC
Calculation of Rebased Rate
Rate year beginning 7/1/18
Based on CRs with 6/30/17 year end

	Per Quarter Hour
Direct Care	$ 1.56
Care Related	$ 0.28
Administrative and Operating	$ 0.58
Property	$ 0.14
Transportation (see below)	
Rebased Rate	$ 2.56

Facility-specific Transportation Rate:	Per Quarter Hour
Friendship House	$ 0.01
Slidell Adult Day Health Care	$ 0.01
Best Kare Journey ADHC	$ 0.12
Stepping Stones Adult Day Health Care	$ 0.14
John J. Hainkel Home & Rehab Center Adult Day Care	$ 0.18
The Comforts of Home Adult Day Health Care, LLC	$ 0.26
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Abundant Life Adult Day Health Care	$ 0.32
Adult Day Health Care of Carencro, Inc.	$ 0.32
Crescent City Adult Day Health Care	$ 0.32
The Center, Inc.	$ 0.38
Greenwalt Adult Day Health Care	$ 0.39
Belle Oaks	$ 0.40
A&L Personal Care, Inc.	$ 0.41
Promise Pride Adult Day Healthcare Center	$ 0.41
Adult Day Healthcare of Hammond, LLC	$ 0.48
Red River Adult Day Health Care Center	$ 0.51
Active Adult Day Healthcare, LLC	$ 0.51
Baker Wellness Center Adult Daycare	$ 0.57
Hansberry Adult Day Healthcare	$ 0.66
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Chez Elma	$ 0.73
Maison de Williams, Inc.	$ 0.76
Agape Adult Day Health Care	$ 0.99
At Home Adult Day Care, Inc.	$ 2.16

Median to be used for new providers	$ 0.40
Rate for providers with a disclaimer or non-filer status	$ 0.01

Missy Peroyea

From: Denis Beard <Denis.Beard@LA.GOV>
Sent: Friday, July 19, 2019 1:33 PM
To: Missy Peroyea
Subject: RE: ADHC cost report template
Attachments: Scanned from a Xerox Multifunction Printer.pdf

SecureMail.pncpa.com made the following annotations

See attached. Yes, I emailed each provider with the list of all 5 rate components. We had one new facility: Mary Lee's House of Love, provider # 0149351, effective 3-21-2019. Their transportation rate is $0.40 (the median).

From: Missy Peroyea <mperoyea@pncpa.com>
Sent: Friday, July 19, 2019 11:22 AM
To: Denis Beard <Denis.Beard@LA.GOV>
Subject: RE: ADHC cost report template

Denis – do you have the individual provider transportation rates that you can send to me for our files? I assume that each provider will be notified of their facility-specific transportation rate. I don't need the individual letters – a listing would be fine.

Thanks!
Missy

From: Denis Beard [mailto:Denis.Beard@LA.GOV]
Sent: Thursday, July 18, 2019 1:17 PM
To: Catie Mellott <cmellott@MSLC.COM>; Missy Peroyea <mperoyea@pncpa.com>
Subject: ADHC cost report template

SecureMail.pncpa.com made the following annotations

Catie and Missy,

We rebased the ADHC provider rates effective 1-1-2019 (see attached memo). The new rates were input into the system on about 6-11-2019. LDH will recycle the claims for 1-1-2019 through whatever was the last period paid at the old rates.

1. Does this affect the cost report template?
2. If not, is the current template ready for providers to use to file their FYE 6-30-2019 cost reports?

Denis S. Beard
Medicaid Program Manager 2

Louisiana Department of Health (LDH)
Medicaid: Rate Setting and Audit Section

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

M E M O R A N D U M

DATE: August 1, 2019

TO: Administrators of ADHC Facilities

FROM: Denis S. Beard, Medicaid Program Manager

SUBJECT: Submission of FYE 6-30-2019 ADHC Cost Reports

This letter is to remind you that annual cost reports (facility and central office) must be submitted by September 30, 2019. These reports cover the period of July 1, 2018 through June 30, 2019.

Attached are the ADHC payment system rate calculations. The Direct Care Component amount for 7-1-2018 to 12-31-2018 was $1.27 per quarter hour increment. The Direct Care Component amount for 1-1-2019 to 6-30-2019 was $1.56 per quarter hour increment. These amounts will be needed to prepare the Direct Care cost settlement.

Providers should submit the most current cost report template to Myers and Stauffer electronically or by other electronic means (CD, etc.) The template for the cost report can be found at https://www.mslc.com/Louisiana/CaseMix.aspx . On that page, select "Downloads". On the next page, select "ADHC Cost Report Template". Our contractor, Myers & Stauffer, LC, is available to answer your questions or assist you if software problems are encountered. The contractor can be reached at (800) 374-6858. We require that providers use this software for all cost reports. Cost report training is located on the LDH Rate Setting and Audit Section website at http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1573 . On that page, under "Related FILES", select: "ADHC Cost Report Training 8-13-2013 Entire Book".

If cost reports and all accompanying forms are not received by Myers & Stauffer, LC by September 30, 2019, a penalty may be assessed. A penalty of 5% of the total weekly payment for each week of non-compliance may be imposed until the completed cost report is received. The penalty may be increased an additional 5% each month until the completed cost report is submitted to **Myers and Stauffer. All penalties are non-refundable.**

If the calculation of the Direct Care Cost Settlement shows money due to the Department, do not remit payment with the cost report. The provider will be notified of the amount due after desk review or audit.

The maximum salary limits for the Administrator and Assistant Administrator for the fiscal year 2019 are based on the State Civil Service maximums: MR/DD Regional Administrator 1 (1-100 beds) $105,206 and MR/DD Regional Associate Administrator 1 (1-100 beds) $85,883.

Should you have any questions about submission of the cost report you can contact Denis S. Beard, Medicaid Program Manager at (225) 342-6116 or via e-mail at denis.beard@la.gov .

Attachment

DSB

c: Dan Brendel
Kirsten Clebert
Mary J. Mason
Catie Mellott
Mary Norris
Missy Peroyea
Andrew Perilloux
Paul Rhorer
Anissa Young-Ned

ADHC Rate components for 7-1-2018 to 12-31-2018

Direct Care	$	1.27	per quarter hour
Care-Related	$	0.19	per quarter hour
Admin/OP	$	0.82	per quarter hour
Property	$	0.12	per quarter hour
Sub-total	$	2.40	
Transportation			per quarter hour regardless if transportation provided

ADHC Rate components for 1-1-2019 to 6-30-2019

Direct Care	$	1.56	per quarter hour
Care-Related	$	0.28	per quarter hour
Admin/OP	$	0.58	per quarter hour
Property	$	0.14	per quarter hour
Sub-total	$	2.56	
Transportation			per quarter hour regardless if transportation provided

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

M E M O R A N D U M

DATE: August 2 2018

TO: Administrators of ADHC Facilities

FROM: Denis S. Beard, Medicaid Program Manager

SUBJECT: Submission of FYE 6-30-2018 ADHC Cost Reports

This letter is to remind you that annual cost reports (facility and central office) must be submitted by September 30, 2018. These reports cover the period of July 1, 2017 through June 30, 2018.

Attached are the ADHC payment system rate calculations. The Direct Care Component amount for Fiscal Year 2018 was $1.27 per quarter hour increment. This will be needed to prepare the Direct Care cost settlement.

Please note that cost report software is available free of charge on the internet at http://www.mslc.com/Louisiana/CaseMix.aspx . On that page, select "Downloads". On the next page, select "ADHC Cost Report Template". Our contractor, Myers & Stauffer, LC, is available to answer your questions or assist you if software problems are encountered. The contractor can be reached at (800) 374-6858. We require that providers use this software for all cost reports. Cost report training is located on the DHH Rate Setting and Audit Section website at http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1573 . On that page, under "Related FILES", select: "ADHC Cost Report Training 8-13-2013 Entire Book".

If cost reports and all accompanying forms are not received by Myers & Stauffer, LC by September 30, 2018, a penalty may be assessed. A penalty of 5% of the total weekly payment for each week of non-compliance may be imposed until the completed cost report is received. The penalty may be increased an additional 5% each month until the completed cost report is submitted to **Myers and Stauffer. All penalties are non-refundable.**

If the calculation of Direct Care Cost Settlement shows money due to the Department, do not remit payment with the cost report. The provider will be notified of the amount due after desk review or audit.

The maximum salary limits for the Administrator and Assistant Administrator for the fiscal year 2018 are based on the State Civil Service maximums: MR/DD Regional Administrator 1 (1-100 beds) $105,206 and MR/DD Regional Associate Administrator 1 (1-100 beds) $85,883.

Should you have any questions about submission of the cost report you can contact Denis S. Beard, Medicaid Program Manager at (225) 342-6116 or via e-mail at denis.beard@la.gov .

Attachment

DSB

c: Dan Brendel
Kirsten Clebert
Mary J. Mason
Mary Norris
Missy Peroyea
Anissa Young-Ned

ADHC Rate components for Fiscal Year 2018

Direct Care	$	1.27	per quarter hour
Care-Related	$	0.19	per quarter hour
Admin/OP	$	0.82	per quarter hour
Property	$	0.12	per quarter hour
Sub-total	$	2.40	
Transportation			per quarter hour regardless if transportation provided

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

M E M O R A N D U M

DATE: August 15, 2017

TO: Administrators of ADHC Facilities

FROM: Denis S. Beard, Medicaid Program Manager

SUBJECT: Submission of FYE 6-30-2017 ADHC Cost Reports

This letter is to remind you that annual cost reports (facility and central office) must be submitted by September 30, 2017. These reports cover the period of July 1, 2016 through June 30, 2017.

Attached are the ADHC payment system rate calculations. The Direct Care Component amount for Fiscal Year 2017 was $1.27 per quarter hour increment. This will be needed to prepare the Direct Care cost settlement.

Please note that cost report software is available free of charge on the internet at http://www.mslc.com/Louisiana/CaseMix.aspx . On that page, select "Downloads". On the next page, select "ADHC Cost Report Template". Our contractor, Myers & Stauffer, LC, is available to answer your questions or assist you if software problems are encountered. The contractor can be reached at (800) 374-6858. We require that providers use this software for all cost reports. Cost report training is located on the DHH Rate Setting and Audit Section website at http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1573 . On that page, under "Related FILES", select: "ADHC Cost Report Training 8-13-2013 Entire Book".

If cost reports and all accompanying forms are not received by Myers & Stauffer, LC by September 30, 2017, a penalty may be assessed. A penalty of 5% of the total weekly payment for each week of non-compliance may be imposed until the completed cost report is received. The penalty may be increased an additional 5% each month until the completed cost report is submitted to **Myers and Stauffer. All penalties are non-refundable.**

If the calculation of Direct Care Cost Settlement shows money due to the Department, do not remit payment with the cost report. The provider will be notified of the amount due after desk review or audit.

Attached are the maximum salary limits for the Administrator and Assistant Administrator for the fiscal year 2017.

Should you have any questions about submission of the cost report you can contact Denis S. Beard, Medicaid Program Manager at (225) 342-6116 or via e-mail at denis.beard@la.gov .

Attachments

DSB

c: Dan Brendel
Kirsten Clebert
Glenn Deimel
Mary J. Mason
Mary Norris
Missy Peroyea

ADHC Rate components for Fiscal Year 2017

Direct Care	*$*	*1.27*	*per quarter hour*
Care-Related	*$*	*0.19*	*per quarter hour*
Admin/OP	*$*	*0.82*	*per quarter hour*
Property	*$*	*0.12*	*per quarter hour*
Sub-total	*$*	*2.40*	
Transportation			*per quarter hour regardless if transportation provided*

LA. CIVIL SERVICE SALARY MAXIMUMS
FISCAL YEAR 16/17

Job Title		Pay Level		Annual Salary Maximum
MR/DD REGIONAL ADMINISTRATOR 1	(1)	SS419		$93,517
MR/DD REGIONAL ADMINISTRATOR 2	(2)	SS420		$100,069
MR/DD REGIONAL ASSOCIATE ADMINISTRATOR 1	(1)	SS416		$76,336
MR/DD REGIONAL ASSOCIATE ADMINISTRATOR 2	(2)	SS418		$87,402

(1) 1-100 BEDS
(2) 101-300 BEDS

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

M E M O R A N D U M

DATE: August 1, 2016

TO: Administrators of ADHC Facilities

FROM: Denis S. Beard, Medicaid Program Manager

SUBJECT: Submission of FYE 6-30-2016 ADHC Cost Reports

This letter is to remind you that annual cost reports (facility and central office) must be submitted by September 30, 2016. These reports cover the period of July 1, 2015 through June 30, 2016.

Attached are the ADHC payment system rate calculations. The Direct Care Component amount for Fiscal Year 2016 was $1.27 per quarter hour increment. This will be needed to prepare the Direct Care cost settlement.

Please note that cost report software is available free of charge on the internet at http://www.mslc.com/Louisiana/CaseMix.aspx . On that page, select "Downloads". On the next page, select "ADHC Cost Report Template". Our contractors, Myers & Stauffer, LC, are available to answer your questions or assist you if software problems are encountered. The contractors can be reached at (800) 374-6858. We require that providers use this software for all cost reports. Cost report training is located on the DHH Rate Setting and Audit Section website at http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1573 . On that page, under "Related FILES", select: "ADHC Cost Report Training 8-13-2013 Entire Book".

If cost reports and all accompanying forms are not received by Myers & Stauffer, LC by September 30, 2016, a penalty may be assessed. A penalty of 5% of the total weekly payment for each week of non-compliance may be imposed until the completed cost report is received. The penalty may be increased an additional 5% each month until the completed cost report is submitted to **Myers and Stauffer. All penalties are non-refundable.**

If the calculation of Direct Care Cost Settlement shows money due to the Department, do not remit payment with the cost report. The provider will be notified of the amount due after desk review or audit.

Attached are the maximum salary limits for the Administrator and Assistant Administrator for the fiscal year 2016.

Should you have any questions about submission of the cost report you can contact Denis S. Beard, Medicaid Program Manager at (225) 342-6116 or via e-mail at denis.beard@la.gov .

Attachments

DSB

c: Dan Brendel
Kirsten Clebert
Ron Johnson
Mary J. Mason
Missy Peroyea

ADHC Rate components for Fiscal Year 2016

Direct Care	*$*	*1.27*	*per quarter hour*
Care-Related	*$*	*0.19*	*per quarter hour*
Admin/OP	*$*	*0.82*	*per quarter hour*
Property	*$*	*0.12*	*per quarter hour*
Sub-total	*$*	*2.40*	
Transportation			*per quarter hour regardless if transportation provided*

LA. CIVIL SERVICE SALARY MAXIMUMS
FISCAL YEAR 15/16

Job Title		Pay Level		Annual Salary Maximum
MR/DD REGIONAL ADMINISTRATOR 1	(1)	SS419		$93,517
MR/DD REGIONAL ADMINISTRATOR 2	(2)	SS420		$100,069
MR/DD REGIONAL ASSOCIATE ADMINISTRATOR 1	(1)	SS416		$76,336
MR/DD REGIONAL ASSOCIATE ADMINISTRATOR 2	(2)	SS418		$87,402

(1) 1-100 BEDS
(2) 101-300 BEDS

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

M E M O R A N D U M

DATE: September 1, 2015

TO: Administrators of ADHC Facilities

FROM: Denis S. Beard, Medicaid Program Manager

SUBJECT: Submission of FYE 6-30-2015 ADHC Cost Reports

This letter is to remind you that annual cost reports (facility and central office) must be submitted by September 30, 2015. These reports cover the period of July 1, 2014 through June 30, 2015.

Attached are the ADHC payment system rate calculations. The Direct Care Component amount for Fiscal Year 2015 was $1.27 per quarter hour increment. This will be needed to prepare the Direct Care cost settlement.

Please note that cost report software is available free of charge on the internet at http://www.mslc.com/Louisiana/CaseMix.aspx . On that page, select "Downloads". On the next page, select "ADHC Cost Report Template". Our contractors, Myers & Stauffer, LC, are available to answer your questions or assist you if software problems are encountered. The contractors can be reached at (800) 374-6858. We require that providers use this software for all cost reports. Cost report training is located on the DHH Rate Setting and Audit Section website at http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1573 . On that page, under "RELATED ITEMS", select: "ADHC Cost Report Training 8-13-2013 Entire Book".

If a provider experiences unavoidable difficulties in preparing its cost report by the prescribed due date, an extension may be requested. Written requests must be received by the DHH Rate Setting and Audit Section at the e-mail listed below, attention Denis S. Beard, prior to the due date. 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 received by Myers & Stauffer, LC by September 30, 2015 (or extension date granted), a penalty may be assessed. A penalty of 5% of the total monthly payment for each month of non-compliance may be imposed

until the completed cost report is received. The penalty may be increased an additional 5% each month until the completed cost report is submitted to **Myers and Stauffer. All penalties are non-refundable.**

If the calculation of Direct Care Cost Settlement shows money due to the Department, do not remit payment with the cost report. The provider will be notified of the amount due after desk review or audit.

Attached are the maximum salary limits for the Administrator and Assistant Administrator for the fiscal year 2015.

Should you have any questions about submission of the cost report you can contact Denis S. Beard, Medicaid Program Manager at (225) 342-6116 or via e-mail at denis.beard@la.gov .

Attachments

DSB

c: Dan Brendel
Kirsten Clebert
Mary J. Mason
Missy Peroyea
Anissa Young-Ned

ADHC Rate components for Fiscal Year 2015

Direct Care	*$*	*1.27*	*per quarter hour*
Care-Related	*$*	*0.19*	*per quarter hour*
Admin/OP	*$*	*0.82*	*per quarter hour*
Property	*$*	*0.12*	*per quarter hour*
Sub-total	*$*	*2.40*	
Transportation			*per quarter hour regardless if transportation provided*

LA. CIVIL SERVICE SALARY MAXIMUMS
FISCAL YEAR 14/15

Job Title		Pay Level		Annual Salary Maximum
MR/DD REGIONAL ADMINISTRATOR 1	(1)	SS419		$93,517
MR/DD REGIONAL ADMINISTRATOR 2	(2)	SS420		$100,069
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(2) 101-300 BEDS

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Aging and Adult Services

MEMORANDUM **OAAS-P-19-010**

TO: OAAS Adult Day Health Care Providers

FROM: Tara A. LeBlanc
OAAS Assistant Secretary

DATE: June 17, 2019

SUBJECT: New Rate for ADHC Service

As a result of the budget legislation passed in the 2019 Regular Legislative Session, the Louisiana Department of Health (LDH) Office of Aging and Adult Services (OAAS) is funded and authorized to rebase rates paid to Adult Day Health Care providers for the following Medicaid service type:

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Rate year beginning 7/1/18
Based on CRs with 6/30/17 year end

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Rate for providers with a disclaimer or non-filer status	$ 0.01

Missy Peroyea

From: Denis Beard <Denis.Beard@LA.GOV>
Sent: Friday, July 19, 2019 1:33 PM
To: Missy Peroyea
Subject: RE: ADHC cost report template
Attachments: Scanned from a Xerox Multifunction Printer.pdf

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Sent: Friday, July 19, 2019 11:22 AM
To: Denis Beard <Denis.Beard@LA.GOV>
Subject: RE: ADHC cost report template

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Thanks!
Missy

From: Denis Beard [mailto:Denis.Beard@LA.GOV]
Sent: Thursday, July 18, 2019 1:17 PM
To: Catie Mellott <cmellott@MSLC.COM>; Missy Peroyea <mperoyea@pncpa.com>
Subject: ADHC cost report template

SecureMail.pncpa.com made the following annotations

Catie and Missy,

We rebased the ADHC provider rates effective 1-1-2019 (see attached memo). The new rates were input into the system on about 6-11-2019. LDH will recycle the claims for 1-1-2019 through whatever was the last period paid at the old rates.

1. Does this affect the cost report template?
2. If not, is the current template ready for providers to use to file their FYE 6-30-2019 cost reports?

Denis S. Beard
Medicaid Program Manager 2

Louisiana Department of Health (LDH)
Medicaid: Rate Setting and Audit Section

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Aging and Adult Services

MEMORANDUM

TO: **All Adult Day Health Care (ADHC) Waiver Providers**

FROM: **Tara A. LeBlanc** Tara A LeBlanc
Interim Assistant Secretary

DATE: **December 22, 2014**

SUBJECT: **Sign-in and Sign-out Times on Attendance Roster**

This memorandum is being sent as a reminder that all ADHC providers must keep sufficient records for the purposes of continuity of care/support and for adequate monitoring of progress toward outcomes and services received.

All ADHC providers must maintain an attendance log. The attendance log must be completed daily. The daily entry must contain the date the waiver participant is present with the exact time of arrival and exact time of departure. It has come to our attention that some ADHC providers are not documenting the date of attendance or the exact times of arrival and departure. This practice is not in compliance with mandated record-keeping requirements. All ADHC providers who are not properly documenting attendance should immediately take steps to ensure compliance.

Should you have questions about these guidelines for memos you can contact the OAAS Helpline at 1-866-758-5035.

cc: Derek Stafford

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

MEMORANDUM

TO: ADMINISTRATORS OF ADHC FACILITIES

FROM: DENIS S. BEARD, PROGRAM MANAGER
RATE AND AUDIT UNIT

Denis S. Beard

SUBJECT: SUBMISSION OF 2012 - 2013 COST REPORTS

DATE: August 21, 2013

This letter is to remind you that annual cost reports (facility and central office) must be submitted by September 30, 2013. These reports cover the period of July 1, 2012 through June 30, 2013.

Attached are the ADHC payment system rate calculations. The Direct Care Component amount for Fiscal Year 2013 was $1.27 per quarter hour increment. This will be needed to prepare the Direct Care cost settlement.

Please note that cost report software is available free of charge on the internet at http://la.mslc.com/Downloads.aspx. On that page, select "ADHC Template". Our contractors, Myers & Stauffer, LC, are available to answer your questions or assist you if software problems are encountered. The contractors can be reached at (800) 374-6858. We require that providers use this software for all cost reports. Cost report training is located on the DHH Rate & Audit Unit website at http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1573 . On that page, under "RELATED ITEMS", select: "ADHC Cost Report Training 8-13-2013 Entire Book".

If a provider experiences unavoidable difficulties in preparing its cost report by the prescribed due date, an extension may be requested. Written requests must be received by the Rate and Audit Unit at the post office box listed below, attention Denis S. Beard, prior to the due date. 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 received by Myers & Stauffer, LC by September 30, 2013 (or extension date granted), a penalty may be assessed. A penalty of 5% of the total monthly payment for each month of non-compliance may be imposed until the completed cost report is received. The penalty may be increased an additional 5% each month until the completed cost report is submitted to **Myers and Stauffer. All penalties are non-refundable.**

If the calculation of Direct Care Cost Settlement shows money due to the Department, do not remit payment with the cost report. The provider will be notified of the amount due after desk review or audit.

Attached are the maximum salary limits for the Administrator and Assistant Administrator for the fiscal year 2013. We have also attached the Reimbursement Change letter dated June 27, 2011, the ADHC Billing Codes Chart (however, note that for FY 2013 the base rate was $2.40 instead of $2.44) and the Changes Implemented in the Last software.

If you have any questions, please call Denis S. Beard at 225-342-6116. Thank you for your cooperation.

DSB

Attachments

cc: Dan Brendel, Myers & Stauffer
Missy Peroyea, Postlethwaite & Netterville
Rick Henley, OAAS

Medicaid Provider #: _____

Provider Name

Current Rate Component Reimbursement Rates Effective 7-1-2012

(Includes 1.5 % rate cut to all components except Transportation)

Direct Care	$ 1.27	per quarter hour
Care-Related	$ 0.19	per quarter hour
Admin/OP	$ 0.82	per quarter hour
Property	$ 0.12	per quarter hour
Sub-total	$ 2.40	
Transportation		per quarter hour regardless if transportation provided
Rate	**$ 2.40**	**per quarter hour**

Louisiana ADHC Per Quarter Hour Rate Calculation
Cost Report YE 6/30/09
Provider Specific Transportation per Quarter Hour Cost

Provider Number	Provider Name	Adjusted Provider Specific Transportation Per Quarter Hour Cost
		0.70
		0.20
		0.19
		0.17
		0.18
		0.19
		0.22
		0.22
		0.26
		0.12
		0.44
		0.01
		0.15
		0.03
		0.25
		0.18
		0.33
		0.45
		0.42
		0.01
		0.00
		0.23
		0.37
		0.44
		0.20
		0.01
		0.26
		0.08
		0.17
		0.29
	Median Quarter Hour Transportation Cost	0.20

LA. CIVIL SERVICE SALARY MAXIMUMS

SALARY TITLE		FISCAL YEAR 12/13 MAXIMUM
SS 419 - MR/DD REG ADM I (1-100 BEDS)		$93,517
SS 420 - MR/DD REG ADM II (101-300 BEDS)		$100,069
SS 416 - MR/DD REG ASSOC ADM I (1-100 BEDS)		$76,336
SS 418 - MR/DD REG ASSOC ADM II (101-300 BEDS)		$87,402

Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Aging and Adult Services

MEMORANDUM

OAAS-P-11-004

TO: Adult Day Health Care Providers

FROM: Don Gregory
Medicaid Director

Hugh Eley
Office of Aging and Adult Services Assistant Secretary

DATE: June 27, 2011

SUBJECT: Change in Adult Day Health Care (ADHC) Medicaid Reimbursement Methodology

Effective July 1, 2011 the Department of Health and Hospitals will implement a change in how Adult Day Health Care (ADHC) services are reimbursed by the Medicaid Program. ADHC providers will be reimbursed at a quarter hour (15-minute) rate of pay instead of a "per diem" or daily rate. Refer to the attachment entitled "Service Procedure Codes/Rates" (OAAS-PC-06-001) reflecting this change.

This means that instead of ADHC providers receiving a daily payment for each day of attendance, ADHC providers will now receive payment based on each quarter hour the recipient is at the facility. For example, if a recipient attended the facility from 8:00 a.m. to 2:00 p.m. for a total of six hours, the billing should reflect 24 units (*e.g.*, 6 hours x 4 quarter units = 24 units) on the actual day of attendance.

Transportation time to and from the facility is not billable. For example, if a recipient is picked up at 7:30 a.m. and does not arrive at the facility until 8:00 a.m., billing would start at 8:00 a.m. Likewise, if the recipient departs the facility at 2:00 p.m. and arrives home at 2:30 p.m., billing would end at 2:00 p.m. Time spent accompanying a recipient to medical and social activities is a billable ADHC service.

Billable services cannot exceed 10 hours (40 units) each day and 50 hours (200 units) each prior authorized week. The prior authorized week begins on Sunday at 12:00 a.m. and ends on the following Sunday at 12:00 a.m. Unused portions of the prior authorized weekly allocation cannot be saved or borrowed from one week for use in another week. ADHC providers can now provide services to individuals on weekends and bill for attendance on weekends should they choose to do so, provided that services billed do not exceed 10 hours per day and 50 hours per week.

With the exception of the 36 days per quarter attendance requirement, all reimbursement and policy changes reflected in this memorandum will likewise apply to the provision of ADHC services in the Elderly and Disabled Adult Waiver. ADHC Waiver recipients are still required to attend a minimum of 36 days per calendar quarter unless they have an approved exception by OAAS or its designee to attend less often.

ADHC providers will continue to bill electronically using the 837I or on the UB-04 claim form. However, please note the following:

- In form locator #39 or loop 2300, for Value Code 80, providers should enter the total number of quarter hour units billed (total hours of attendance x 4 quarter units = Total Units), not the total number of days;
- Units billed will now be in increments of 15 minutes, not individual days.

Statistical Resources Incorporated (SRI) has changed all prior authorizations for dates of service July 1, 2011 forward to reflect quarter hour billing instead of per-day billing. Each per diem unit is being converted to 40 units (10 hours). ADHC providers must only bill for time that the recipient is signed in and out for ADHC services. SRI will forward to all ADHC providers detailed information on what changes have been made in the Louisiana Statistical Tracking (LAST) software.

If you have any questions, please contact OAAS regional office.

DG/HE/RH

Attachment

cc: OAAS Staff
Support Coordination Agencies
Medicaid Waiver Assistance and Compliance Section
Medicaid Policy Development and Implementation Section
Medicaid Rate and Audit Section
Medicaid Health Standards Section
Statistical Resources Incorporated

ADULT DAY HEALTH CARE
Level of Care 27

SERVICE PROCEDURE CODES/RATES
Effective July 1, 2011

Provider Type	HCBS Waiver Service Description	Procedure Code	HIPAA Service Description	Units
85	Adult Day Health Care	932	Medical Rehabilitation Day Program	$2.44 plus provider specific transportation rate (per 15 minute unit)
08	Support Coordination	T0012	ADHC Case Management	Monthly $140.00
08	Transition Intensive Support Coordination	T0013	ADHC High Risk Case Management	Monthly $157.00
08	Transition Service	T2038	Community Transition, Waiver	$1,500.00 One time fee

Changes Implemented in Last (Louisiana Service Tracking System) for ADHC Waiver Service Providers

Effective July 1, 2011, ADHC providers will be reimbursed at a quarter hour rate of pay instead of a daily rate.

Statistical Resources, Inc has implemented this new policy in your prior authorizations and in the LAST software

Prior Authorization Changes

All prior authorizations (PAs) issued by SRI that began prior to July 1, 2011 have been modified to end on June 30, 2011. These prior authorizations for the procedure code HR932 allow for 1 unit of service per day. The PA numbers remain unchanged.

New PAs were issued with begin dates of July 1, 2011 and ending on the original end date of your prior PAs. These PAs are for 15-minute units of service. The procedure code remains the same – HR932.

> For ADHC Waiver recipients, 40 15-minute units (10 hours) were automatically issued on the new PA for each daily unit that was authorized on the original PA.
>
> For EDA Waiver recipients, 24 15-minute units (6 hours) were automatically issued on the new PA for each daily unit that was authorized on the original PA.
>
> Because a PA can be issued for a maximum of 9,999 units, if the conversion from old daily units to new 15-minute units resulted in more than 9,999 units for the balance of the CPOC year, two contiguous PAs were issued for the rest of the CPOC year.

As new CPOCs or new revisions are received by SRI, the number of 15-minute units issued per day will match the schedule on the CPOC and will not be automatically issued for the maximum of 40 units per day.

Changes in the LAST Software

Because each ADHC facility now has their individual 15-minute rate, you must update your rate in LAST in order for the LAST reports to be accurate or if your billing software uses the rates listed in LAST.

> To update your rate in LAST, you must have Administrative rights in LAST. Go to the supervisor menu, labeled SUPER on the main screen. If SUPER is not active, you do not have administrative rights. Click on SUPER. Choose PROCEDURE CODES from the list. The procedure code screen will appear. In

the Target Filter box, select ADHC and tab out of the box. The procedure cost displayed will be HR932 beginning on 7/1/2007. Click on the 'next' arrow to cycle through the procedure code / active date range combination until you reach the procedure code HR932 that begins on 7/1/2011. The rate will be listed as 12.00. Edit this record and change the rate to your agency's rate. Save the record. Note: If you do not know your rate, please contact OAAS.

You must also edit the rate for ADHC services for EDA waiver participants. In the target filter box, select ELDR and tab out. The procedure cost displayed will be HR932 beginning on 6/1/2009. Click on the 'next' arrow to cycle through the procedure code / active date range combination until you reach the procedure code HR932 that begins on 7/1/2011. The rate will be listed as 12.00. Edit this record and change the rate to your agency's rate. Save the record.

The **Service Log** form has been changed to remove the Appointment indicator. It is no longer required. No other changes have been made. You will still enter the time that the recipient arrived at the facility and left the facility on the service log. If the individual departs the facility and then comes back in the same day, you would enter two service records for that individual, indicating each arrival and departure time. The software will calculate total units for the day by dividing the total time at the facility for the day by 15 minutes and rounding down to the nearest whole number.

For example, if the individual arrived at 8:22 am and left at 12:30 pm and then returned at 1:45 pm and left at 4:30 pm, the total time for the day would be 413 minutes. Dividing 413 by 15 equals 27.53 units. Rounding 27.53 down, you can bill for 27 units.

You do not have to do the math. All reports in LAST have been modified to calculate 15-minute units.

Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Aging and Adult Services

MEMORANDUM

OAAS-P-11-004

TO: Adult Day Health Care Providers

FROM: Don Gregory
Medicaid Director

Hugh Eley
Office of Aging and Adult Services Assistant Secretary

DATE: June 27, 2011

SUBJECT: Change in Adult Day Health Care (ADHC) Medicaid Reimbursement Methodology

Effective July 1, 2011 the Department of Health and Hospitals will implement a change in how Adult Day Health Care (ADHC) services are reimbursed by the Medicaid Program. ADHC providers will be reimbursed at a quarter hour (15-minute) rate of pay instead of a "per diem" or daily rate. Refer to the attachment entitled "Service Procedure Codes/Rates" (OAAS-PC-06-001) reflecting this change.

This means that instead of ADHC providers receiving a daily payment for each day of attendance, ADHC providers will now receive payment based on each quarter hour the recipient is at the facility. For example, if a recipient attended the facility from 8:00 a.m. to 2:00 p.m. for a total of six hours, the billing should reflect 24 units (*e.g.,* 6 hours x 4 quarter units = 24 units) on the actual day of attendance.

Transportation time to and from the facility is not billable. For example, if a recipient is picked up at 7:30 a.m. and does not arrive at the facility until 8:00 a.m., billing would start at 8:00 a.m. Likewise, if the recipient departs the facility at 2:00 p.m. and arrives home at 2:30 p.m., billing would end at 2:00 p.m. Time spent accompanying a recipient to medical and social activities is a billable ADHC service.

Billable services cannot exceed 10 hours (40 units) each day and 50 hours (200 units) each prior authorized week. The prior authorized week begins on Sunday at 12:00 a.m. and ends on the following Sunday at 12:00 a.m. Unused portions of the prior authorized weekly allocation cannot be saved or borrowed from one week for use in another week. ADHC providers can now provide services to individuals on weekends and bill for attendance on weekends should they choose to do so, provided that services billed do not exceed 10 hours per day and 50 hours per week.

With the exception of the 36 days per quarter attendance requirement, all reimbursement and policy changes reflected in this memorandum will likewise apply to the provision of ADHC services in the Elderly and Disabled Adult Waiver. ADHC Waiver recipients are still required to attend a minimum of 36 days per calendar quarter unless they have an approved exception by OAAS or its designee to attend less often.

ADHC providers will continue to bill electronically using the 837I or on the UB-04 claim form. However, please note the following:

- In form locator #39 or loop 2300, for Value Code 80, providers should enter the total number of quarter hour units billed (total hours of attendance x 4 quarter units = Total Units), not the total number of days;
- Units billed will now be in increments of 15 minutes, not individual days.

Statistical Resources Incorporated (SRI) has changed all prior authorizations for dates of service July 1, 2011 forward to reflect quarter hour billing instead of per-day billing. Each per diem unit is being converted to 40 units (10 hours). ADHC providers must only bill for time that the recipient is signed in and out for ADHC services. SRI will forward to all ADHC providers detailed information on what changes have been made in the Louisiana Statistical Tracking (LAST) software.

If you have any questions, please contact OAAS regional office.

DG/HE/RH

Attachment

cc: OAAS Staff
Support Coordination Agencies
Medicaid Waiver Assistance and Compliance Section
Medicaid Policy Development and Implementation Section
Medicaid Rate and Audit Section
Medicaid Health Standards Section
Statistical Resources Incorporated

Current Rate Component Reimbursement Rates

Direct Care	$	1.29	per quarter hour
Care-Relate	$	0.20	per quarter hour
Admin/OP	$	0.83	per quarter hour
Property	$	0.12	per quarter hour
Transportation			per quarter hour regardless if transportation provided

Louisiana ADHC Per Quarter Hour Rate Calculation
Cost Report YE 6/30/09
Provider Specific Transportation per Quarter Hour Cost

Provider Number	Provider Name	Adjusted Provider Specific Transportation Per Quarter Hour Cost
43514	Achieve to Succeed Adult Day Health Care, Inc.	0.70
72146	Active Adult Day Healthcare, LLC	0.20
13136	Adult Day Health Care of Carencro, Inc.	0.19
31730	Adult Day Health Care/Kingsley House	0.17
36228	Alpha House Adult Day Health Care	0.18
13449	Angel Manor Adult Day Health Care	0.19
64336	Baker Wellness Center Adult Daycare	0.22
92345	CHRISTUS Schumpert Adult Day Health Care	0.22
11269	Compassionate Covenant Adult Day Health Care, Inc.	0.26
17976	Day Haven Adult Day Health Care, LLC	0.12
62252	Daybreak Adult Day Health Care/Lafayette Council	0.44
43023	East Jefferson General Hospital Adult Day Care	0.01
32748	Franciscan House Adult Day Health	0.15
39786	Friendship House	0.03
43865	Grace and Glory Adult Day Health Care Center	0.25
55675	Greenwalt Adult Day Health Care	0.18
62257	Hansberry Adult Day Health Care	0.33
43816	LA Y.E.S., Inc.	0.45
55794	Maison de Williams, Inc.	0.42
31728	New Directions Adult Day Health Care	0.01
97138	Norco Adult Day Health Care	0.00
77986	Paradise Adult Day Health Care	0.23
31731	Red River Adult Day Health Care Center	0.37
62092	Rest Adult Day Health Care	0.44
56088	Seniors' Club Adult Day Health Care Center	0.20
47593	Slidell Adult Day Healthcare	0.01
38508	St. Francis Adult Day Care/PACE	0.26
62783	Stepping Stones Adult Day Health Care	0.08
17757	The Center for Better Living Adult Day Health Care, Inc.	0.17
32587	The Center, Inc.	0.29
	Median Quarter Hour Transportation Cost	0.20

ADULT DAY HEALTH CARE
Level of Care 27

SERVICE PROCEDURE CODES/RATES
Effective July 1, 2011

Provider Type	HCBS Waiver Service Description	Procedure Code	HIPAA Service Description	Units
85	Adult Day Health Care	932	Medical Rehabilitation Day Program	$2.44 plus provider specific transportation rate (per 15 minute unit)
08	Support Coordination	T0012	ADHC Case Management	Monthly $140.00
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08	Transition Service	T2038	Community Transition, Waiver	$1,500.00 One time fee

Bobby Jindal
GOVERNOR

Bruce D. Greenstein
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State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

MEMORANDUM

TO: ADMINISTRATORS OF ADHC FACILITIES

FROM: DENIS S. BEARD, PROGRAM MANAGER
RATE AND AUDIT UNIT

Denis S. Beard

SUBJECT: SUBMISSION OF 2011 - 2012 COST REPORTS

DATE: September 6, 2012

This letter is to remind you that annual cost reports (facility and central office) must be submitted by September 30, 2012. These reports cover the period of July 1, 2011 through June 30, 2012.

Attached are the ADHC payment system rate calculations. The Direct Care Component amount for Fiscal Year 2012 was $1.29 per quarter hour increment. This will be needed to prepare the Direct Care cost settlement.

Please note that cost report software is available free of charge on the internet at http://la.mslc.com/Downloads.aspx. Our contractors, Myers & Stauffer, LC, are available to answer your questions or assist you if software problems are encountered. The contractors can be reached at (800) 374-6858. We require that providers use this software for all cost reports.

If a provider experiences unavoidable difficulties in preparing its cost report by the prescribed due date, an extension may be requested. Written requests must be received by the Rate and Audit Unit at the post office box listed below, attention Denis S. Beard, prior to the due date. 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 received by Myers & Stauffer, LC by September 30, 2012 (or extension date 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, do not remit payment with the cost report. The provider will be notified of the amount due after desk review or audit.

Attached are the maximum salary limits for the Administrator and Assistant Administrator for the fiscal year 2012. We have also attached the Reimbursement Change letter dated June 27, 2011, the ADHC Billing Codes Chart and the Changes Implemented in the Last software.

If you have any questions, please call Denis S. Beard at 225-342-6116. Thank you for your cooperation.

DSB

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cc: Dan Brendel, Myers & Stauffer
Missy Peroyea, Postlethwaite & Netterville

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Cost Report YE 6/30/09
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		0.20
		0.19
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		0.22
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		0.01
		0.15
		0.03
		0.25
		0.18
		0.33
		0.45
		0.42
		0.01
		0.00
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Provider Name

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Bobby Jindal
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Department of Health and Hospitals
Office of Aging and Adult Services

MEMORANDUM

OAAS-P-11-004

TO: Adult Day Health Care Providers

FROM: Don Gregory
Medicaid Director

Hugh Eley
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DATE: June 27, 2011

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Statistical Resources Incorporated

ADULT DAY HEALTH CARE
Level of Care 27

SERVICE PROCEDURE CODES/RATES
Effective July 1, 2011

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> For EDA Waiver recipients, 24 15-minute units (6 hours) were automatically issued on the new PA for each daily unit that was authorized on the original PA.
>
> Because a PA can be issued for a maximum of 9,999 units, if the conversion from old daily units to new 15-minute units resulted in more than 9,999 units for the balance of the CPOC year, two contiguous PAs were issued for the rest of the CPOC year.

As new CPOCs or new revisions are received by SRI, the number of 15-minute units issued per day will match the schedule on the CPOC and will not be automatically issued for the maximum of 40 units per day.

Changes in the LAST Software

Because each ADHC facility now has their individual 15-minute rate, you must update your rate in LAST in order for the LAST reports to be accurate or if your billing software uses the rates listed in LAST.

> To update your rate in LAST, you must have Administrative rights in LAST. Go to the supervisor menu, labeled SUPER on the main screen. If SUPER is not active, you do not have administrative rights. Click on SUPER. Choose PROCEDURE CODES from the list. The procedure code screen will appear. In

the Target Filter box, select ADHC and tab out of the box. The procedure cost displayed will be HR932 beginning on 7/1/2007. Click on the 'next' arrow to cycle through the procedure code / active date range combination until you reach the procedure code HR932 that begins on 7/1/2011. The rate will be listed as 12.00. Edit this record and change the rate to your agency's rate. Save the record. Note: If you do not know your rate, please contact OAAS.

You must also edit the rate for ADHC services for EDA waiver participants. In the target filter box, select ELDR and tab out. The procedure cost displayed will be HR932 beginning on 6/1/2009. Click on the 'next' arrow to cycle through the procedure code / active date range combination until you reach the procedure code HR932 that begins on 7/1/2011. The rate will be listed as 12.00. Edit this record and change the rate to your agency's rate. Save the record.

The **Service Log** form has been changed to remove the Appointment indicator. It is no longer required. No other changes have been made. You will still enter the time that the recipient arrived at the facility and left the facility on the service log. If the individual departs the facility and then comes back in the same day, you would enter two service records for that individual, indicating each arrival and departure time. The software will calculate total units for the day by dividing the total time at the facility for the day by 15 minutes and rounding down to the nearest whole number.

For example, if the individual arrived at 8:22 am and left at 12:30 pm and then returned at 1:45 pm and left at 4:30 pm, the total time for the day would be 413 minutes. Dividing 413 by 15 equals 27.53 units. Rounding 27.53 down, you can bill for 27 units.

You do not have to do the math. All reports in LAST have been modified to calculate 15-minute units.

To: Providers of Adult Day Health Care Services

From: Randy Davidson, Section Director
Supplemental Payments Section / Rate & Audit Unit
Department of Health and Hospitals

Re: Reporting of Client Quarter Hours Paid and Payable at end of period on June 30, 2012 ADHC cost reports

Date: September 28, 2012

The Department has received inquiries from some providers regarding the completion of Schedule B, lines 8 and 9 of the ADHC cost report version 2.6. Specifically, certain providers have indicated that they did not maintain records of the quarter hours of service provided to their ADHC clients during the 7/1/11 to 6/30/12 cost report period. These providers have indicated that they have no reliable quarter hours data available to report on Schedule B, lines 8 and 9. While the Department considers the maintenance of appropriate census records to be an important responsibility of ADHC providers, the Department is aware that the completion of Schedule B, lines 8 and 9 by a provider who did not maintain such records throughout the year will be difficult and may not result in accurate and meaningful disclosure. Therefore, for providers who did not maintain records of quarter hours of service provided to the ADHC clients during the FY 11/12 cost report period, the Department suggests that providers report "0" on Schedule B, lines 8 and 9. Providers who did maintain accurate records of quarter hours of service provided should report such information on Schedule B, lines 8 and 9.

In order to assist providers in maintaining appropriate records of quarter hours of service provided to ADHC clients for the 7/1/12 to 6/30/13 cost report period, the Department has attached an example of a monthly census report to be maintained by ADHC providers. In each daily box, the provider will document the number of quarter hours of service provided to each client based on the time the client arrived and departed the facility. This report should be maintained for ALL clients (ie, Medicaid, private, VA, etc). It is imperative that the provider maintain separate logs of arrival and departure times for ALL clients in order to support the quarter hours of service documented on the monthly census reports. Utilization of this report will facilitate the completion of Schedule B, lines 8 and 9 for the 7/1/12 to 6/30/13 and future cost reports.

In the absence of the reporting of reliable quarter hours of service data on the FY 11/12 ADHC cost report, the provider must report accurate attendance days on Schedule B, line 5 of the cost report. These days will be used by the Department in the rate setting process.

In conclusion, providers should start maintaining documentation of accurate quarter hours of service provided NOW so that such information will be available for the accurate completion of the FY 12/13 ADHC cost report.

Example

Medicaid

ABCD ADHC
Census Detail - Quarter Hours of Service
August 2012

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Totals
Client Name	W	TH	F	S	SU	M	T	W	TH	F	S	SU	M	T	W	TH	F	S	SU	M	T	W	TH	F	S	SU	M	T	W	TH	F	
Louis Miller	27	0	26	0	0	25	25	25	25	24	0	0	28	25	25	25	25	0	0	25	25	25	25	26	0	0	0	0	0	0	0	431
LJ Miller	28	28	28	0	0	28	28	28	28	28	0	0	28	28	28	28	28	0	0	28	28	28	28	28	0	0	28	28	28	28	28	644
Patrick Greene	20	24	25	0	0	17	20	20	20	28	0	0	22	22	22	14	21	0	0	19	23	27	22	23	0	0	24	29	18	18	18	496
John Smith	27	0	26	0	0	25	25	25	25	24	0	0	28	0	0	0	0	0	0	0	0	0	0	0	0	0		Discharged on 8/24				205
Mary Smith													Admit on 8/15		28	18	26	0	0	25	25	25	28	23	0	0	22	20	20	20	20	300
																																0
																																0
																																0
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																																0
																																0
																																0
																																0
Totals	102	52	105			95	98	98	98	104			106	75	103	85	100			97	101	105	103	100			74	77	66	66	66	2076

Note: A separate page should be done for each type of client (private, other, VA, etc.)

Admissions:

1. Mary Smith- 8/15
2.
3.

Discharges

1. John Smith was admitted to the hospital on 8/14 & d/ced to a nursing home on 8/24
2.
3.

Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

MEMORANDUM

TO: ADMINISTRATORS OF ADHC FACILITIES

FROM: DENIS S. BEARD, PROGRAM MANAGER
RATE AND AUDIT REVIEW

Denis S. Beard

SUBJECT: SUBMISSION OF 2010 - 2011 COST REPORTS

DATE: August 16, 2011

This letter is to remind you that annual cost reports (facility and central office) must be submitted by September 30, 2011. These reports cover the period of July 1, 2010 through June 30, 2011.

Attached are the ADHC payment system rate calculations. The Direct Care Component amount for Fiscal Year 2011 was $28.38 from 7-1-2010 to 7-31-2010, and $27.81 from 8-1-2010 to 6-30-2011. This will be needed to prepare the Direct Care cost settlement.

Please note that cost report software is available free of charge on the internet at http://la.mslc.com/Downloads.aspx. Our contractors, Myers & Stauffer, LC, are available to answer your questions or assist you if software problems are encountered. The contractors can be reached at (800) 374-6858. We require that providers use this software for all cost reports.

If a provider experiences unavoidable difficulties in preparing its cost report by the prescribed due date, an extension may be requested. Written requests must be received by Rate and Audit Review at the post office box listed below, attention Denis S. Beard, prior to the due date. 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 received by Myers & Stauffer, LC by September 30, 2011 (or extension date 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, do not remit payment with the cost report. The provider will be notified of the amount due after desk review or audit.

Attached are the maximum salary limits for the Administrator and Assistant Administrator for the fiscal year 2011. We have also attached the Census Records letter dated June 2, 2009 that was previously faxed to all ADHC providers.

If you have any questions, please call Denis S. Beard at 225-342-6116. Thank you for your cooperation.

DSB

Attachments

cc: Dan Brendel, Myers & Stauffer
Missy Peroyea, Postlethwaite & Netterville

ADHC

Calculation of August 1, 2010 Rate Cut

Rate year beginning 7/1/10

Allocating cut ratably among cost categories

	10/11 Rate effective 7/1/2010	Rate Cut - 2%	Revised Rate Effective 08/1 /2010
Direct Care	$ 28.38	$ (0.57)	$ 27.81
Care Related	$ 4.47	$ (0.09)	$ 4.38
Admin & Operating	$ 28.23	$ (0.56)	$ 27.67
Capital	$ 3.32	$ (0.07)	$ 3.25
	$ 64.40	$ (1.29)	$ 63.11

Bobby Jindal
GOVERNOR

Anthony Keck
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

MEMORANDUM

TO: Administrators of Adult Day Health Care Centers

FROM: Don Gregory
Medicaid Director

SUBJECT: Reimbursement Rates for August 1, 2010

DATE: August 13, 2010

A calculation of your facility's rate effective for services from August 1, 2010 through June 30, 2011 is attached. This rate reflects budget reduction as directed by Act 11 of the 2010 Regular Session of the Louisiana Legislature.

Facilities are required by the ADHC Payment Methodology Rule published October 20, 2008, to spend no less than 90% of the direct care component in the rate. If a facility fails to expend the direct care expenditure floor, the department will cost settle their direct care.

If additional information is required, please contact Rate and Audit Review at (225) 342-6116.

DG:KB:bt

Attachment

cc: Erin Rabalais, Health Standards
Susan Jackson, OAAS
Lois Harpole, UNISYS-Provider Enrollment
Pam Sunseri, OAAS
Missy Peroyea, P&N
Bob Hicks, M&S
Steve Buco, SRL
Alicia Smith, OAAS

DHH Rate & Audit Review

ADHC FY11 Prospective Payment System Rate Calculation
Effective August 1, 2010

Calculation of the PPS Rate:

Direct Care Component		**$27.81**
Care Related Component		**$4.38**
Administrative & Operating Component		**$27.67**
Property Component		**$3.25**
Total PPS rate effective August 1, 2010		**$63.11**

Calculation of the Direct Care Floor:

Direct Care Rate Component	**$27.81**
90%	**90%**
Direct Care Floor Effective August 1, 2010	**$25.03**

Due to Budgetary Reduction the rate has been reduced by $1.29

Prepared by DHH Rate & Audit Review
August 12, 2010

LA. CIVIL SERVICE SALARY MAXIMUMS

SALARY TITLE		FISCAL YEAR 10/11 MAXIMUM
SS 419 - MR/DD REG ADM I (1-100 BEDS)		$93,517
SS 420 - MR/DD REG ADM II (101-300 BEDS)		$100,069
SS 416 - MR/DD REG ASSOC ADM I (1-100 BEDS)		$76,336
SS 418 - MR/DD REG ASSOC ADM II (101-300 BEDS)		$87,402

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

June 2, 2009

Administrators
Adult Day Health Care (ADHC) facilities

Dear Administrators:

RE: Census Records

As a result of the recent audits of all of the Adult Day Health Care (ADHC) providers in Louisiana, it appears that some providers are not maintaining appropriate census records. Because ADHC Medicaid reimbursement rates are determined based on a provider's costs and census days, it is important that providers report accurate census days on their cost reports and that census days reported on the cost reports are supported by accurate census records.

ADHC providers must maintain monthly census reports which reflect the daily attendance of ALL clients at the facility, regardless of the payment source or whether the census days are unpaid. Every person who attends the program should be listed on the census and his/her presence or absence should be marked on a daily basis. The census should indicate if a client was not present for the minimum five hours per day and a census day should not be counted. Also, if a client is absent due to an illness or a hospitalization, the census should reflect that. All admissions, discharges, deaths, and transfers to another payor type should be reflected on the census. A unique code should be used to document each type of occurrence.

Separate daily census records should be maintained by payor class. Clients who are not yet approved for Medicaid services should be reported on the private census until they are certified to receive Medicaid funding.

The monthly census reports should reflect the number of days attended by each client and the total census days for the month by payor class. The twelve monthly census reports should be used to determine the annual census days to be reported on the cost report.

See the attached example of an appropriate monthly census report.

In addition to the census document, the provider should maintain detail documentation of each type of census occurrence. For admissions, the provider should have an admissions document and related nurses' notes, etc. that document the date of admission. For discharges and deaths, the provider should have a discharge summary and related nurses' notes, etc. that document the date of discharge / death. For extended absences, the provider should have nurses' notes, etc. that document the period of absence and whether the absence was related to an illness or hospitalization.

Sincerely,

Denis S. Beard

Denis S. Beard
Medicaid Program Manager

DSB

Attachment

cc: Melissa Peroyea, Postlethwaite & Netterville, APAC

Census Detail

Apr 2008

(Medicaid)

Client Name	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Totals
	P	P	P	P			P	P	P	N	N			P	P	P	P	P			P	P	N	N	N			P	N	P	16
	P	P	P	P			P	P	N	N	P			P	P	P	P	P			P	P	P	N	N			P	P	P	18
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	22
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			N	P	P	P	P			P	P	P	21
	P	P	P	P			P	N	P	P	P			P	P	P	N	P			P	P	P	P	P			P	P	P	20
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	N			N	N	N	18
	P	P	P	P			P	P	P	P	P			N	P	P	P	P			P	P	P	P	P			P	P	P	21
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	22
	P	P	P	P			N	P	P	P	P			P	P	P	P	P			P	P	P	P	N			P	P	P	20
	P	N	N	N			P	P	P	P	P			P	N	N	N	P			P	P	N	N	P			P	P	P	14
	P	P	P	N			P	P	P	P	P			P	P	P	P	P			N	P	P	P	P			P	P	P	20
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	N			P	P	P	21
	P	N	P	N			N	P	N	P	N			N	P	N	P	P			N	P	N	P	N			N	P	N	10
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			N	N	N	P	P			P	N	P	18
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	22
	N	N	P	P			P	P	N	P	N			N	N	N	N	N			N	P	P	P	P			P	P	P	12
	P	P	P	P			P	P	P	P	P			P	N	N	N	P			P	P	P	P	P			P	P	P	19
	P	N	P	N			N	P	N	P	N			N	P	N	P	N			N	P	N	P	N			N	P	N	9
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	22
	N	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	21
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	22
	P	P	P	P			P	P	N	P	P			P	P	P	P	P			P	P	N	P	P			P	P	N	19
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	22
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	22
	P	P	N	P			N	P	P	P	N			P	P	N	N	P			P	P	P	P	N			P	N	P	15
	P	P	P	N			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	21
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	22
	P	P	N	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	21
	N	N	N	N			N	N	N	N	N			N	N	N	N	N			N	N	N	N	N			N	N	N	0
	P	P	P	P			P	P	N	N	P			P	N	P	P	P			N	N	N	N	N			P	N	N	12
											N			N	P	N	P	N			P	P	P	P	P			P	P	P	10
Totals																															552

A- Admission
D- Discharge
E- Expired
P- Present
N- Not Present

Bobby Jindal
GOVERNOR

Anthony Keck
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

MEMORANDUM

TO: ADMINISTRATORS OF ADHC FACILITIES

FROM: BETH TARANTO, PROGRAM MANAGER
RATE AND AUDIT REVIEW

RE: SUBMISSION OF 2009 - 2010 COST REPORTS

DATE: August 10, 2010

This letter is to remind you that annual cost reports (facility and central office) must be submitted by September 30, 2010. These reports cover the period of July 1, 2009 through June 30, 2010.

Attached is the ADHC payment system rate calculation. The Direct Care Component amount for Fiscal Year 2010 was $28.38 which will be needed to prepare the Direct Care cost settlement.

Please note that cost report software is available free of charge on the internet at http://la.mslc.com/Downloads.aspx. Our contractors, Myers & Stauffer, LC, are available to answer your questions or assist you if software problems are encountered. The contractors can be reached at (800) 374-6858. We require that providers use this software for all cost reports.

If a provider experiences unavoidable difficulties in preparing its cost report by the prescribed due date, an extension may be requested. Written requests must be received by Rate and Audit Review at the post office box listed below, attention Beth Taranto, prior to the due date. 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 received by Myers & Stauffer, LC by September 30, 2010 (or extension date 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, do not remit payment with the cost report. The provider will be notified of the amount due after desk review or audit.

Attached are the maximum salary limits for the Administrator and Assistant Administrator for the fiscal years 2010 and 2011. We have also attached the Census Records letter dated June 2, 2009 that was previously faxed to all ADHC providers.

Adult Day Health Care Provider Cost Report Training will be held August 26, 2010, from 1:00pm – 4:30pm at the Department of Health & Hospitals: Bienville Conference Room 118, 628 N. 4th Street, Baton Rouge, LA 70802. Registration forms were mailed to providers on July 30, 2010. If you need additional information, please call Diane Bridges at Postlethwaite & Netterville at 225-922-4655.

If you have any questions, please call Beth Taranto at 225-342-5773. Thank you for your cooperation.

Attachment

BT/mjm

cc: Bob Hicks, Myers & Stauffer
Missy Peroyea, Postlethwaite & Netterville

DHH Rate & Audit Review

ADHC FY10 Prospective Payment System Rate Calculation
Effective July 1, 2009

Calculation of the PPS Rate:

Direct Care Base Component	$33.05	
Support Coordination Services (Case Management) Reduction	**($4.67)**	
Total Direct Care Component Effective July 1, 2009		$28.38
Care Related		$4.47
Administrative & Operating		$28.23
Property Component		$3.32
Total PPS rate including Case Management Reduction		**$64.40**

Calculation of the Direct Care Floor:

Direct Care Rate Component	$28.38
90%	90%
Direct Care Floor Effective July 1, 2009	**$25.54**

Prepared by DHH Rate & Audit Review
July 17, 2009

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

June 2, 2009

Administrators
Adult Day Health Care (ADHC) facilities

Dear Administrators:

RE: Census Records

As a result of the recent audits of all of the Adult Day Health Care (ADHC) providers in Louisiana, it appears that some providers are not maintaining appropriate census records. Because ADHC Medicaid reimbursement rates are determined based on a provider's costs and census days, it is important that providers report accurate census days on their cost reports and that census days reported on the cost reports are supported by accurate census records.

ADHC providers must maintain monthly census reports which reflect the daily attendance of ALL clients at the facility, regardless of the payment source or whether the census days are unpaid. Every person who attends the program should be listed on the census and his/her presence or absence should be marked on a daily basis. The census should indicate if a client was not present for the minimum five hours per day and a census day should not be counted. Also, if a client is absent due to an illness or a hospitalization, the census should reflect that. All admissions, discharges, deaths, and transfers to another payor type should be reflected on the census. A unique code should be used to document each type of occurrence.

Separate daily census records should be maintained by payor class. Clients who are not yet approved for Medicaid services should be reported on the private census until they are certified to receive Medicaid funding.

The monthly census reports should reflect the number of days attended by each client and the total census days for the month by payor class. The twelve monthly census reports should be used to determine the annual census days to be reported on the cost report.

See the attached example of an appropriate monthly census report.

In addition to the census document, the provider should maintain detail documentation of each type of census occurrence. For admissions, the provider should have an admissions document and related nurses' notes, etc. that document the date of admission. For discharges and deaths, the provider should have a discharge summary and related nurses' notes, etc. that document the date of discharge / death. For extended absences, the provider should have nurses' notes, etc. that document the period of absence and whether the absence was related to an illness or hospitalization.

Sincerely,

Denis S. Beard

Denis S. Beard
Medicaid Program Manager

DSB

Attachment

cc: Melissa Peroyea, Postlethwaite & Netterville, APAC

LA. CIVIL SERVICE SALARY MAXIMUMS

SALARY TITLE	FISCAL YEAR 09/10 MAXIMUM	FISCAL YEAR 10/11 MAXIMUM
SS 419 - MR/DD REG ADM I (1-100 BEDS)	$93,517	$93,517
SS 420 - MR/DD REG ADM II (101-300 BEDS)	$100,069	$100,069
SS 416 - MR/DD REG ASSOC ADM I (1-100 BEDS)	$76,336	$76,336
SS 418 - MR/DD REG ASSOC ADM II (101-300 BEDS)	$87,402	$87,402

BHSF RATE & AUDIT REVIEW CENSUS FORM FOR NURSING FACILITIES 1 **PAYOR TYPE OR SPECIALIZED SERVICES**_____ Page ____ of ____ 5

1 **Facility Name:** _____ 1 **Month:**_____ **Year:**_____

Resident Name	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total Census Days	Total Allowable Leave Days	Paid Bed Hold Days	Total Provider Fee Days
																																8	8		7
Totals																																			
Employee Initials																																			

6

3 & 4

Resident Status Codes:

A = Admission Count as a census day
P = Present Count as a census day
Hom = Home Leave Count as an allowable leave day
Hsp = Hospital Leave Count as an allowable leave day
D = Discharge Do not count as a census day
E = Expired Count as a census day
BH = Paid Bed Hold Do not count as census day (Count only as paid bed hold day)
UBH = Unpaid Bed Hold Do not count as a census day or paid bed hold day

Note: Provider fees are to be paid on all paid and/or occupied bed days. (Total census days plus total allowable leave days plus paid bed hold days = total provider fee days.)

(02/24/05)

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

MEMORANDUM

TO: ADMINISTRATORS OF ADHC FACILITIES

FROM: BETH TARANTO, ACTING DIRECTOR
RATE AND AUDIT REVIEW

RE: SUBMISSION OF 2008 - 2009 COST REPORTS

DATE: JUNE 26, 2009

This letter is to remind you that annual cost reports (facility and central office) must be submitted by September 30, 2009. These reports cover the period of July 1, 2008 through June 30, 2009.

Attached is a revised Schedule K of the cost report. Due to a reduction in Support Coordination Services effective January 1, 2009, there are two Direct Care Component amounts within the fiscal year. The component amount for the period of 07/01/08 through 12/31/08 is $28.60 and the component amount for the period of 01/01/09 through 06/30/09 is $23.93 (as indicated on the enclosed rate letters). This revised page will assist in the preparation of your 2008–2009 electronic cost report.

Please note that cost report software is available free of charge on the internet at http://la.mslc.com/Downloads.aspx. Our contractors, Myers & Stauffer, LC, are available to answer your questions or assist you if software problems are encountered. The contractors can be reached at (800) 374-6858. We require that providers use this software for all cost reports.

If a provider experiences unavoidable difficulties in preparing its cost report by the prescribed due date, an extension may be requested. Written requests must be received by Rate and Audit Review at the post office box listed below, attention Beth Taranto prior to the due date. 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 received by Myers & Stauffer, LC by September 30, 2009 (or extension date 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 do not remit payment with the cost report. The provider will be notified of the amount due after desk review or audit.

Attached are the maximum salary limits for the Administrator and Assistant Administrator for the fiscal years 2009 and 2010. We have also attached the Census Records letter that was previously fax to all ADHC providers.

If you have any questions, please call Beth Taranto at 225-342-5773. Thank you for your cooperation.

Attachment

BT/cq

cc: Bob Hicks, Myers & Stauffer
Missy Peroyea, Postlethwaite & Netterville

Schedule K

Facility Name:

Cost Report Period:

Direct Care Cost Settlement

	(a) Medicaid Days		(b) Direct Care Cost Per Day		(c) Medicaid Direct Care Revenue	(d) Medicaid Direct Care Revenue 90%
07/01/08 thru 12/31/08:						
1a.		x	28.60	=	0	0
01/01/09 thru 6/30/09:						
2a.		x	23.93	=	0	0

	(a) Medicaid Days		(b) Direct Care Costs Per Day	(c) Medicaid Direct Care Costs
2		x		0

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	
Direct Care Wage Enhancement	**$1.11**	
Total Direct Care Component Effective February 9, 2007		$28.60
Care Related		$4.82
Administrative & Operating		$27.66
Property		$4.37
Total PPS rate including Rate Enhancement Effective 2/9/2007		**$65.45**

Calculation of the Direct Care Floor:

Direct Care Rate Component	$28.60
90%	90%
Direct Care Floor Effective February 9, 2007	**$25.74**

Prepared by DHH Rate & Audit Review
February 9, 2007

DHH Rate & Audit Review

ADHC FY09 Prospective Payment System Rate Calculation
Effective January 1, 2009

Calculation of the PPS Rate:

Direct Care Base Component	$27.49	
Direct Care Wage Enhancement	$1.11	
Support Coordination Services (Case Management) Reduction	**($4.67)**	
Total Direct Care Component Effective January 1, 2009		$23.93
Care Related Component		$4.82
Administrative & Operating Component		$27.66
Property Component		$4.37
Total PPS rate including Case Management Reduction		**$60.78**

Calculation of the Direct Care Floor:

Direct Care Rate Component	$23.93
90%	90%
Direct Care Floor Effective January 1, 2009	**$21.54**

Prepared by DHH Rate & Audit Review
January 16, 2009

LA. CIVIL SERVICE SALARY MAXIMUMS

SALARY TITLE	FISCAL YEAR 08/09 MAXIMUM	FISCAL YEAR 09/10 MAXIMUM
SS 419 - MR/DD REG ADM I (1-100 BEDS)	$93,517	$93,517
SS 420 - MR/DD REG ADM II (101-300 BEDS)	$100,069	$100,069
SS 416 - MR/DD REG ASSOC ADM I (1-100 BEDS)	$76,336	$76,336
SS 418 - MR/DD REG ASSOC ADM II (101-300 BEDS)	$87,402	$87,402

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals

Bureau of Health Services Financing

June 2, 2009

Administrators
Adult Day Health Care (ADHC) facilities

Dear Administrators:

RE: Census Records

As a result of the recent audits of all of the Adult Day Health Care (ADHC) providers in Louisiana, it appears that some providers are not maintaining appropriate census records. Because ADHC Medicaid reimbursement rates are determined based on a provider's costs and census days, it is important that providers report accurate census days on their cost reports and that census days reported on the cost reports are supported by accurate census records.

ADHC providers must maintain monthly census reports which reflect the daily attendance of ALL clients at the facility, regardless of the payment source or whether the census days are unpaid. Every person who attends the program should be listed on the census and his/her presence or absence should be marked on a daily basis. The census should indicate if a client was not present for the minimum five hours per day and a census day should not be counted. Also, if a client is absent due to an illness or a hospitalization, the census should reflect that. All admissions, discharges, deaths, and transfers to another payor type should be reflected on the census. A unique code should be used to document each type of occurrence.

Separate daily census records should be maintained by payor class. Clients who are not yet approved for Medicaid services should be reported on the private census until they are certified to receive Medicaid funding.

The monthly census reports should reflect the number of days attended by each client and the total census days for the month by payor class. The twelve monthly census reports should be used to determine the annual census days to be reported on the cost report.

See the attached example of an appropriate monthly census report.

In addition to the census document, the provider should maintain detail documentation of each type of census occurrence. For admissions, the provider should have an admissions document and related nurses' notes, etc. that document the date of admission. For discharges and deaths, the provider should have a discharge summary and related nurses' notes, etc. that document the date of discharge / death. For extended absences, the provider should have nurses' notes, etc. that document the period of absence and whether the absence was related to an illness or hospitalization.

Sincerely,

Denis S. Beard

Denis S. Beard
Medicaid Program Manager

DSB

Attachment

cc: Melissa Peroyea, Postlethwaite & Netterville, APAC

Census Detail

Apr 2008

(Medicaid)

Client Name	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Totals
	P	P	P	P			P	P	P	N	N			P	P	P	P	P			P	P	N	N	N			P	N	P	16
	P	P	P	P			P	P	N	N	P			P	P	P	P	P			P	P	P	N	N			P	P	P	18
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	22
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			N	P	P	P	P			P	P	P	21
	P	P	P	P			P	N	P	P	P			P	P	P	N	P			P	P	P	P	P			P	P	P	20
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	N			N	N	N	18
	P	P	P	P			P	P	P	P	P			N	P	P	P	P			P	P	P	P	P			P	P	P	21
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	22
	P	P	P	P			N	P	P	P	P			P	P	P	P	P			P	P	P	P	N			P	P	P	20
	P	N	N	N			P	P	P	P	P			P	N	N	N	P			P	P	N	N	P			P	P	P	14
	P	P	P	N			P	P	P	P	P			P	P	P	P	P			N	P	P	P	P			P	P	P	20
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	N			P	P	P	21
	P	N	P	N			N	P	N	P	N			N	P	N	P	P			N	P	N	P	N			N	P	N	10
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			N	N	N	P	P			P	N	P	18
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	22
	N	N	P	P			P	P	N	P	N			N	N	N	N	N			N	P	P	P	P			P	P	P	12
	P	P	P	P			P	P	P	P	P			P	N	N	N	P			P	P	P	P	P			P	P	P	19
	P	N	P	N			N	P	N	P	N			N	P	N	P	N			N	P	N	P	N			N	P	N	9
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	22
	N	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	21
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	22
	P	P	P	P			P	P	N	P	P			P	P	P	P	P			P	P	N	P	P			P	P	N	19
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	22
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	22
	P	P	N	P			N	P	P	P	N			P	P	N	N	P			P	P	P	P	N			P	N	P	15
	P	P	P	N			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	21
	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	22
	P	P	N	P			P	P	P	P	P			P	P	P	P	P			P	P	P	P	P			P	P	P	21
	N	N	N	N			N	N	N	N	N			N	N	N	N	N			N	N	N	N	N			N	N	N	0
	P	P	P	P			P	P	N	N	P			P	N	P	P	P			N	N	N	N	N			P	N	N	12
											N			N	P	N	P	N			P	P	P	P	P			P	P	P	10
Totals																															552

A- Admission
D- Discharge
E- Expired
P- Present
N- Not Present

BHSF RATE & AUDIT REVIEW CENSUS FORM **PAYOR TYPE** _____ **Page ____ of ____**

Facility Name: _____ **Month:**_____ **Year:**_____

Resident Name	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total Census Days
Totals																																
Employee Initials																																

Resident Status Codes:

A = Admission Count as a census day **D = Discharge Do not count as a census day**

P = Present Count as a census day **E = Expired Count as a census day**

(02/24/05)

ADULT DAY HEALTH CARE (ADHC)
IMPLEMENTATION OF PRIOR AUTHORIZATION OF SERVICES
AND
REMOVAL OF THE USE OF SPANNING DATE BILLING FOR CLAIMS SUBMISSIONS

In order to be consistent with all Long Term Care Programs provided by the Office of Aging and Adult Services, two important changes are being made which impact Adult Day Health Care (ADHC) services and billing.

I. Prior Authorization (PA) of Adult Day Health Care Services

Prior Authorization of ADHC services will be implemented effective with July 1, 2007 billing. This change means ADHC facilities must complete the process to request prior authorization for all services prior to billing Unisys for these services, and providers must use the appropriate, accurate prior authorization number on each claim submitted in order to be paid for these services.

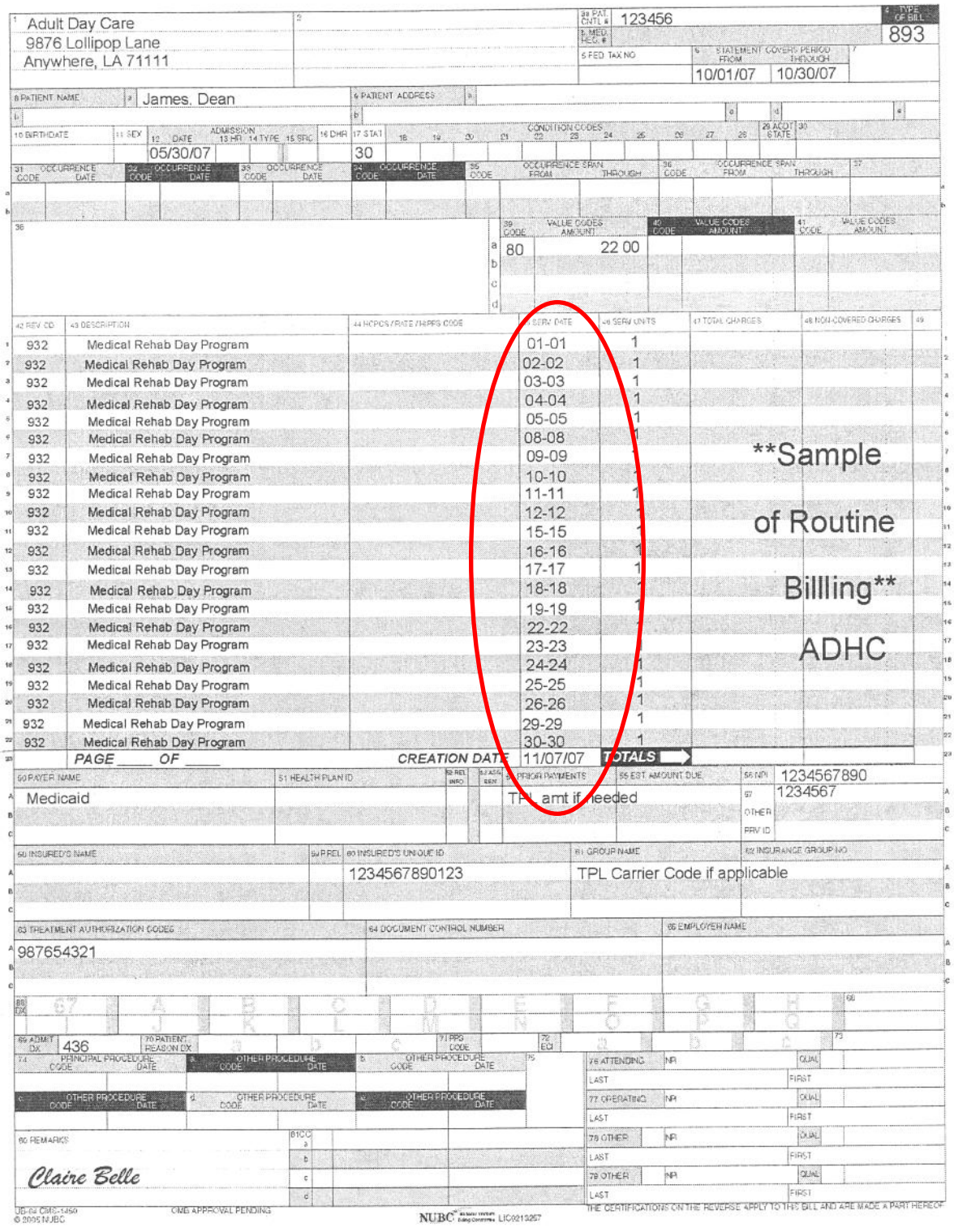
Beginning July 1, 2007, all ADHC providers must have an approved PA number and required documentation of services, or **payment will not be made for the services.**

II. Discontinuation of Spanning Date Billing for Claims Submission

In conjunction with the prior authorization requirement, ADHC providers will no longer be allowed to bill spanning dates of service on claims submitted for payment. A separate claim line must be billed for each date of service for each recipient.

These changes apply to both electronic and hard copy billing of services.

This packet contains both claim examples and billing instructions for correct completion of claims in order to be paid for the services rendered.


Adult Day Care
9876 Lollipop Lane
Anywhere, LA 71111
123456
893
10/01/07
10/30/07
James, Dean
05/30/07
30
80
22 00
932 Medical Rehab Day Program 01-01 1
932 Medical Rehab Day Program 02-02 1
932 Medical Rehab Day Program 03-03 1
932 Medical Rehab Day Program 04-04 1
932 Medical Rehab Day Program 05-05 1
932 Medical Rehab Day Program 08-08 1
932 Medical Rehab Day Program 09-09 1
932 Medical Rehab Day Program 10-10 1
932 Medical Rehab Day Program 11-11 1
932 Medical Rehab Day Program 12-12 1
932 Medical Rehab Day Program 15-15 1
932 Medical Rehab Day Program 16-16 1
932 Medical Rehab Day Program 17-17 1
932 Medical Rehab Day Program 18-18 1
932 Medical Rehab Day Program 19-19 1
932 Medical Rehab Day Program 22-22 1
932 Medical Rehab Day Program 23-23 1
932 Medical Rehab Day Program 24-24 1
932 Medical Rehab Day Program 25-25 1
932 Medical Rehab Day Program 26-26 1
932 Medical Rehab Day Program 29-29 1
932 Medical Rehab Day Program 30-30 1
PAGE ____ OF ____
CREATION DATE 11/07/07
TOTALS
**Sample
of Routine
Billing**
ADHC
Medicaid
TPL amt if needed
1234567890
1234567
1234567890123
TPL Carrier Code if applicable
987654321
436
Claire Belle

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.

2313.1 Use of Provider's Unique Cost Centers.--Based on the provider's individual accounting system, a provider may elect to use its unique cost centers in lieu of the recommended cost centers on the cost reporting forms for cost finding purposes, subject to the following provisions.

A. Each cost center must meet the definition of a cost center as expressed in §2302.8.

B. Each cost center to be established must:

1. Be separately identified in the provider's accounting system with any direct costs recorded on a regular ongoing basis throughout the accounting period, not only period ending adjusting entries;

2. For general service cost centers, be placed in the allocation sequence in an order such that the cost center serving the most other cost centers, while receiving benefits from the least number of cost centers, is allocated earliest in the sequence. (See §2306.1.); and

3. For general service cost centers, use a single statistical basis of allocation which accurately measures the amount of service rendered by that cost center to the other cost centers. (See §2307.)

C. The intermediary must be satisfied that the provider's use of its unique cost centers will result in a more accurate cost finding.

D. A written request must be submitted to the intermediary 90 days prior to the end of the cost reporting period for which it applies and must be approved by the intermediary within 60 days from the date of receipt. The intermediary's approval, which applies to both the cost centers and the proposed basis of allocation, must be furnished in writing and is binding for the initially approved and all subsequent cost reporting periods until a subsequent request is approved.

2313.2 Special Applications.--It is not possible to prescribe standard allocation rules for every situation. Such determination needs to be made by providers subject to approval by the intermediary. However, the following are some common issues which have arisen over the years.

A. Admitting.--Where the admitting department serves both inpatients and outpatients, gross charges would be an adequate basis for allocation. However, where the admitting department serves only inpatients (i.e., the provider has a separate outpatient registry), all the costs of inpatient admitting may be allocated to the general routine and special care areas on the basis of number of admissions. The cost of the outpatient registry should be allocated to only the benefiting outpatient departments on a reasonable basis.

B. Utilization Review.--Where hospital utilization review costs are identified as a separate general service cost center, and if the utilization review program serves only inpatients, these costs may be allocated to the general routine and special care cost centers, as appropriate, on a reasonable basis (e.g., number of reviews or patient days). (See §2126ff.)

C. Home Health Disciplines.--Each of the six home health disciplines (see §2302.14) must be reported as a single cost center as specified on the cost reporting forms. The creation of subcategories (or any form thereof) of any of these cost centers is not allowed.

D. Renal Dialysis.--Notwithstanding the provisions of §§2307 and 2313.1, providers furnishing renal dialysis services must retain the capability of completing the renal dialysis worksheets (e.g., Supplemental Worksheet I series for hospitals) by modality.

E. Periodic Time Studies.--Periodic time studies, in lieu of ongoing time reports, may be used to allocate direct salary and wage costs. However, the time studies used must meet the following criteria:

1. The time records to be maintained must be specified in a written plan submitted to the intermediary no later than 90 days prior to the end of the cost reporting period to which the plan is to apply. The intermediary must respond in writing to the plan within 60 days from the date of receipt of the request, whether approving, modifying, or denying the plan.

2. A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.

3. Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).

4. The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.

5. No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.

6. The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.

7. The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

The intermediary may require the use of different, or additional, weeks in the study in its response to the provider's request for approval and may prospectively require changes in the provider's request as applied to subsequent cost reporting periods.

2314. LIMITATION OF ALLOCATION OF INDIRECT COSTS WHERE ANCILLARY SERVICES ARE FURNISHED UNDER ARRANGEMENTS

A. "No Overhead Allocation" Method.--

1. Where a provider furnishes ancillary services to Medicare patients under arrangements with others, the provider must pay the supplier and request reimbursement from the Medicare program. Where a provider simply arranges for such services for non-Medicare patients, and does not pay the non-Medicare portion of such services, its books will reflect only the cost of the Medicare portion. Therefore, allocation of indirect costs to a cost center which includes only the cost of the Medicare portion would result in excessive assignment of indirect costs to the program. Since services were also arranged for non-Medicare patients, part of the overhead costs should be allocated to that group.

Consequently, in the foregoing situation, no indirect costs may be allocated to the Medicare portion. Instead, the total indirect costs will be allocated to all other departments so that each of these departments will absorb proportionately those indirect costs which otherwise would have been allocated to the arranged for services. In this way, Medicare will share in such indirect costs in the proportion that it shares in the costs of all other services furnished directly by the provider.

6

QUARTERS
6/30/2012

Medicaid per patients

JULY	4554
AUG	6025
SEPT	5604
OCT	4501
NOV	4753
DEC	4531
JAN	5063
FEB	4603
MAR	4798
APR	4431
MAY	4731
JUNE	3823
TOTAL	57417

Date Range: 07/01/11 - 07/31/11 **Target Population:** ALL
Detail: Daily

Case: ALL **SSN:** ALL **Name:** ALL

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-08/25/2011	200		673	673	$ 1776.72
				07/01/2011	36 / 36	36 / 36	
				07/05/2011	32 / 32	32 / 32	
				07/06/2011	37 / 37	37 / 37	
				07/07/2011	38 / 38	38 / 38	
				07/08/2011	37 / 37	37 / 37	
				07/11/2011	38 / 38	38 / 38	
				07/12/2011	38 / 38	38 / 38	
				07/13/2011	36 / 36	36 / 36	
				07/14/2011	34 / 34	34 / 34	
				07/15/2011	34 / 34	34 / 34	
				07/18/2011	35 / 35	35 / 35	
				07/19/2011	34 / 34	34 / 34	
				07/20/2011	33 / 33	33 / 33	
				07/21/2011	7 / 7	7 / 7	
				07/22/2011	38 / 38	38 / 38	
				07/25/2011	37 / 37	37 / 37	
				07/26/2011	28 / 28	28 / 28	
				07/27/2011	26 / 26	26 / 26	
				07/28/2011	40 / 40	40 / 40	
				07/29/2011	35 / 35	35 / 35	
				Subtotal:			$ 1776.72
				Total:			$ 1776.72

4554
4355
+199

Date Range: 07/01/11 - 07/31/11 **Target Population: ALL**
Detail: Daily

Case: ALL **SSN: ALL** **Name: ALL**

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-07/18/2011	200		236	236	$ 623.04
				07/05/2011	24 / 24	24 / 24	
				07/06/2011	20 / 20	20 / 20	
				07/07/2011	25 / 25	25 / 25	
				07/08/2011	24 / 24	24 / 24	
				07/11/2011	25 / 25	25 / 25	
				07/12/2011	21 / 21	21 / 21	
				07/13/2011	21 / 21	21 / 21	
				07/14/2011	36 / 36	36 / 36	
				07/15/2011	20 / 20	20 / 20	
				07/18/2011	20 / 20	20 / 20	
HR932		07/19/2011-08/18/2011	200		199	199	$ 525.36
				07/19/2011	22 / 22	22 / 22	
				07/20/2011	24 / 24	24 / 24	
				07/21/2011	23 / 23	23 / 23	
				07/22/2011	20 / 20	20 / 20	
				07/25/2011	20 / 20	20 / 20	
				07/26/2011	20 / 20	20 / 20	
				07/27/2011	21 / 21	21 / 21	
				07/28/2011	24 / 24	24 / 24	
				07/29/2011	25 / 25	25 / 25	
				Subtotal:			$ 1148.40
				Total:			$ 1148.40

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-05/11/2012	200		269	269	$ 710.16
				07/01/2011	33 / 33	33 / 33	
				07/08/2011	33 / 33	33 / 33	
				07/11/2011	34 / 34	34 / 34	
				07/15/2011	34 / 34	34 / 34	
				07/18/2011	34 / 34	34 / 34	
				07/22/2011	33 / 33	33 / 33	
				07/25/2011	33 / 33	33 / 33	
				07/29/2011	35 / 35	35 / 35	
				Subtotal:			$ 710.16
				Total:			$ 710.16

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent	
HR932	[redacted]	07/01/2011-04/08/2012	200		192	191	$ 504.24	**Daily cap applied**
				07/12/2011	38 / 38	38 / 38		
				07/18/2011	37 / 37	37 / 37		
				07/26/2011	37 / 37	37 / 37		
				07/27/2011	41 / 41	40 / 40		**Daily cap applied**
				07/29/2011	39 / 39	39 / 39		
				Subtotal:			$ 504.24	
				Total:			$ 504.24	

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-01/21/2012	200		258	258	$ 681.12
				07/01/2011	29 / 29	29 / 29	
				07/05/2011	32 / 32	32 / 32	
				07/06/2011	34 / 34	34 / 34	
				07/07/2011	31 / 31	31 / 31	
				07/14/2011	29 / 29	29 / 29	
				07/19/2011	34 / 34	34 / 34	
				07/20/2011	35 / 35	35 / 35	
				07/22/2011	34 / 34	34 / 34	
				Subtotal:			$ 681.12
				Total:			$ 681.12

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: Case #: SSN: Target: ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932	[redacted]	07/01/2011-01/23/2012	200		622	622	$ 1642.08
				07/01/2011	21 / 21	21 / 21	
				07/05/2011	25 / 25	25 / 25	
				07/06/2011	37 / 37	37 / 37	
				07/07/2011	23 / 23	23 / 23	
				07/08/2011	39 / 39	39 / 39	
				07/12/2011	39 / 39	39 / 39	
				07/13/2011	39 / 39	39 / 39	
				07/14/2011	38 / 38	38 / 38	
				07/15/2011	38 / 38	38 / 38	
				07/18/2011	38 / 38	38 / 38	
				07/19/2011	38 / 38	38 / 38	
				07/20/2011	22 / 22	22 / 22	
				07/21/2011	25 / 25	25 / 25	
				07/22/2011	26 / 26	26 / 26	
				07/25/2011	37 / 37	37 / 37	
				07/26/2011	27 / 27	27 / 27	
				07/27/2011	37 / 37	37 / 37	
				07/28/2011	37 / 37	37 / 37	
				07/29/2011	36 / 36	36 / 36	
				Subtotal:			$ 1642.08
				Total:			$ 1642.08

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-09/06/2011	200		189	189	$ 498.96
				07/01/2011	29 / 29	29 / 29	
				07/11/2011	31 / 31	31 / 31	
				07/12/2011	30 / 30	30 / 30	
				07/15/2011	28 / 28	28 / 28	
				07/18/2011	26 / 26	26 / 26	
				07/25/2011	28 / 28	28 / 28	
				07/29/2011	17 / 17	17 / 17	
				Subtotal:			$ 498.96
				Total:			$ 498.96

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-06/29/2012	200		154	154	$ 406.56
				07/19/2011	34 / 34	34 / 34	
				07/20/2011	22 / 22	22 / 22	
				07/21/2011	38 / 38	38 / 38	
				07/26/2011	38 / 38	38 / 38	
				07/27/2011	22 / 22	22 / 22	
				Subtotal:			$ 406.56
				Total:			$ 406.56

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: Case #: SSN: Target: ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-06/08/2012	200		478	478	$ 1261.92
				07/01/2011	22 / 22	22 / 22	
				07/05/2011	35 / 35	35 / 35	
				07/06/2011	26 / 26	26 / 26	
				07/08/2011	37 / 37	37 / 37	
				07/11/2011	35 / 35	35 / 35	
				07/12/2011	28 / 28	28 / 28	
				07/13/2011	27 / 27	27 / 27	
				07/14/2011	28 / 28	28 / 28	
				07/15/2011	36 / 36	36 / 36	
				07/18/2011	24 / 24	24 / 24	
				07/19/2011	31 / 31	31 / 31	
				07/20/2011	28 / 28	28 / 28	
				07/21/2011	24 / 24	24 / 24	
				07/25/2011	27 / 27	27 / 27	
				07/26/2011	24 / 24	24 / 24	
				07/28/2011	25 / 25	25 / 25	
				07/29/2011	21 / 21	21 / 21	
				Subtotal:			$ 1261.92
				Total:			$ 1261.92

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-11/03/2011	200		331	331	$ 873.84
				07/01/2011	24 / 24	24 / 24	
				07/05/2011	8 / 8	8 / 8	
				07/07/2011	30 / 30	30 / 30	
				07/12/2011	31 / 31	31 / 31	
				07/14/2011	33 / 33	33 / 33	
				07/15/2011	30 / 30	30 / 30	
				07/18/2011	28 / 28	28 / 28	
				07/19/2011	24 / 24	24 / 24	
				07/21/2011	8 / 8	8 / 8	
				07/26/2011	32 / 32	32 / 32	
				07/27/2011	22 / 22	22 / 22	
				07/28/2011	26 / 26	26 / 26	
				07/29/2011	35 / 35	35 / 35	
				Subtotal:			$ 873.84
				Total:			$ 873.84

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-11/29/2011	200		111	111	$ 293.04
				07/11/2011	24 / 24	24 / 24	
				07/13/2011	21 / 21	21 / 21	
				07/20/2011	21 / 21	21 / 21	
				07/25/2011	24 / 24	24 / 24	
				07/27/2011	21 / 21	21 / 21	
				Subtotal:			$ 293.04
				Total:			$ 293.04

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ADHC

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-08/24/2011	200		383	383	$ 1011.12
				07/01/2011	36 / 36	36 / 36	
				07/06/2011	19 / 19	19 / 19	
				07/07/2011	25 / 25	25 / 25	
				07/08/2011	26 / 26	26 / 26	
				07/11/2011	30 / 30	30 / 30	
				07/12/2011	30 / 30	30 / 30	
				07/14/2011	28 / 28	28 / 28	
				07/15/2011	33 / 33	33 / 33	
				07/19/2011	28 / 28	28 / 28	
				07/20/2011	33 / 33	33 / 33	
				07/21/2011	28 / 28	28 / 28	
				07/22/2011	5 / 5	5 / 5	
				07/25/2011	32 / 32	32 / 32	
				07/26/2011	30 / 30	30 / 30	
				Subtotal:			$ 1011.12
				Total:			$ 1011.12

LOUISIANA DEPARTMENT OF HEALTH & HOSPITALS
LOUISIANA SERVICE TRACKING (v 3.70)

SERVICE SUMMARY

Name: **Case #:** **SSN:** **Target:** ELDR

Procedure Code	PA #	PA Date	Weekly Cap	Service Date	Units Delivered	Units Allowed	Spent
HR932		07/01/2011-09/30/2011	200		460	460	$ 1214.40
				07/01/2011	25 / 25	25 / 25	
				07/05/2011	27 / 27	27 / 27	
				07/06/2011	12 / 12	12 / 12	
				07/07/2011	20 / 20	20 / 20	
				07/08/2011	26 / 26	26 / 26	
				07/12/2011	24 / 24	24 / 24	
				07/13/2011	27 / 27	27 / 27	
				07/14/2011	25 / 25	25 / 25	
				07/15/2011	24 / 24	24 / 24	
				07/18/2011	23 / 23	23 / 23	
				07/19/2011	24 / 24	24 / 24	
				07/20/2011	22 / 22	22 / 22	
				07/21/2011	25 / 25	25 / 25	
				07/22/2011	24 / 24	24 / 24	
				07/25/2011	25 / 25	25 / 25	
				07/26/2011	27 / 27	27 / 27	
				07/27/2011	27 / 27	27 / 27	
				07/28/2011	26 / 26	26 / 26	
				07/29/2011	27 / 27	27 / 27	
				Subtotal:			$ 1214.40
				Total:			$ 1214.40

Adult Day Healthcare Attendance Waiver July, 2011

#	Client Name	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		Days
		31			31	31	31	31	0			31	31	31	31	31			31	31	31	18	31			31	31	31	31	31			607	20
		20			33	32	33	32	33			32	32	31	32	33			33	33	33	34	33			32	33	33	33	33			673	21
		31			0	31	31	31	33			31	31	32	31	31			31	31	31	33	31			31	31	31	31	31			625	20
		29			33	32	26	32	33			32	32	32	32	33			33	33	33	34	33			32	33	33	33	31			674	21
		26			0	27	0	30	32			0	32	0	31	31			0	31	28	32	0			0	31	0	29	30			390	13
		33			0	0	0	0	0			0	0	0	0	0			0	0	0	0	0			0	0	0	0	0			33	1
		33			33	32	33	32	33			32	32	32	32	33			33	33	33	34	28			32	33	33	23	33			672	21
		28			28	0	28	0	28			30	0	30	0	31			31	0	31	0	31			31	0	31	0	31			389	13
		28			28	0	28	0	28			30	0	30	0	31			31	0	31	0	0			31	0	31	0	31			358	12
		28			0	30	28	0	28			30	0	30	0	31			31	0	31	0	31			31	0	31	0	31			391	13
		31			33	31	31	31	33			31	31	31	31	31			31	31	31	33	31			31	31	31	31	31			657	21
		318			219	246	269	219	281			279	221	279	220	316			285	223	313	218	249			282	223	285	211	313			5469	176