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 and Hospitals (DHH).

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

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.

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).

§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. 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;

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.

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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).

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

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

B. Individuals who desire their name to be placed on the ADHC waiver registry shall be screened to determine whether they meet nursing facility level of care. Only individuals who pass this screen 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).

§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 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;

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

3. individuals admitted to a nursing facility who are approved for a stay of more than 90 days; 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).

Chapter 23. Services

§2301. Covered Services

A. The following services are available to recipients 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. ADHC services furnished as specified in the plan of care at the 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. An adult day health care center shall, at a minimum, furnish the following services:

a. assistance with activities of daily living;

b. health and nutrition counseling;

c. individualized, exercise program;

d. individualized, goal directed recreation program;

e. health education classes;

f. meals shall not constitute a "full nutritional regimen" (three meals per day) but shall include a minimum of two snacks and a nutritional lunch;

g. individualized health/nursing services;

i. monitoring vital signs appropriate to the diagnosis and medication regimen of each recipient no less frequently than monthly;

ii. administering medications and treatments in accordance with physicians’ orders;

iii. monitoring self-administration of medications while the recipient is at the ADHC center;

NOTE: All nursing services shall be provided in accordance with acceptable professional practice standards.

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

i. transportation to and from medical and social activities when the participant is accompanied by center staff; and

j. transportation between the participant’s place of residence and the ADHC in accordance with licensing standards.

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:

a. intake;

b. assessment;

c. plan of care development and revision;

d. linkage to direct services and other resources;

e. coordination of multiple services among multiple providers;

f. monitoring/follow-up;

g. reassessment;

h. evaluation and re-evaluation of level of care and need for waiver services;

i. ongoing assessment and mitigation of health, behavioral and personal safety risk;

j. responding to participant crises;

k. critical incident management; and

l. 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. This service is paid up to 180 days prior to transitioning from the nursing facility when adequate pre-transition support and activity are provided and documented. This service is available to participants during transition from a nursing facility to the community.

4. Transition Service. These services that will assist an individual transition from a nursing facility to a living arrangement in a private residence where the individual is directly responsible for his/her own living expenses are time limited, non-recurring set-up expenses available for individuals who have been offered and approved for an adult day health care 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. Allowable expenses are those necessary to enable the individual to establish a basic household that does not constitute room and board, but include:

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

b. specific set up fees or deposits (telephone, electric gas, water and other such necessary housing set-up fees or deposits); and

c. essential furnishings to establish basic living arrangements; and health and welfare assurances (pest control/eradication, fire extinguisher, smoke detector and first aid supplies/kit).

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

C. These services do not include monthly rental, mortgage expenses, food, monthly utilities charges and 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. Funds are available one time per $1500 lifetime maximum for specific items as prior approved in the participant’s 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 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).

§2303. Individualized Service Plan

A. All ADHC services shall:

1. be provided according to the individualized service plan;

2. be a result of an interdisciplinary staffing in which the participant and direct care staff participate;

3. be written in terminology which all center personnel can understand;

4. list the identified problems and needs of the participant for which intervention is indicated as identified in assessments, progress notes and medical reports;

5. propose a reasonable, measurable short-term goal for each problem/need;

6. contain the necessary elements of the center's self administration of medication plan, if applicable;

7. use the strengths of the participant in developing approaches to problems;

8. specify the approaches to be used for each problem and that each approach is appropriate to effect positive change for that problem;

9. identify the staff member responsible for carrying out each approach;

10. project the resolution date or review date for each problem;

11. specify the frequency of each approach/service;

12. contain a sufficient explanation of why the participant would require 24-hour care were he/she not receiving ADHC services;

13. include the number of days and time of scheduled attendance each week;

14. include discharge as a goal; and

15. be kept in the participant’s record used by direct care staff.

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).

§2305. Plan of Care

A. The applicant and support coordinator have the flexibility to construct a plan of care that serves the participant’s health and welfare needs. The service package provided under the POC shall include services covered under the adult day health care waiver in addition to services covered under the Medicaid state plan (not to exceed the established service limits for either waiver or state plan services) as well as other services, regardless of the funding source for these services.

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.

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).

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 financial eligibility;

3. initial and continued eligibility for a 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 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).

§2503. Admission Denial or Discharge Criteria

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

1. The individual does not meet the criteria for Medicaid financial eligibility.

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

3. The recipient resides in another state or has a change of residence to another state.

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

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

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

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

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

9. The individual 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).

Chapter 27. Provider Responsibilities

§2701. General Provisions

A. Each adult day health care center shall enter into a provider agreement with the department to provide services which may be reimbursed by the Medicaid Program, and shall agree to comply with the provisions of this Rule.

B. The provider agrees to not request payment unless the participant for whom payment is requested is receiving services in accordance with the ADHC Waiver program provisions.

C. Any provider of services under the ADHC waiver shall not refuse to serve any individual who chooses their agency unless there is documentation to support an inability to meet the individual’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 as specified by OAAS, or its designee, to support service delivery and compliance with the approved POC and will provide said documentation at the request of the department, or its designee.

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).

§2703. Reporting Requirements

A. Support coordinators and direct service providers, including ADHC providers, are obligated to report within specified time lines, 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.

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 recipient 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 ADHC provider in a timely manner.

D. ADHC 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).

Chapter 29. Reimbursement

§2901. General Provisions

A. Development. 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 adult day health care waiver recipients 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 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 and Human Resources, Office of Family Security, LR 11:626 (June 1985), amended LR 13:181 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1154 (September 1997), repromulgated LR 30:2041 (September 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 32:2257 (December 2006), LR 34:2164 (October 2008), repromulgated LR 34:2569 (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).

§2903. 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 patient 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 facilities shall be subject to a full-scope, annual on-site audit. All ADHC cost reports shall be filed with a fiscal year from July 1 through June 30.

1. When a provider ceases to participate in the ADHC Waiver Program, the provider must file a cost report covering a period under the 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 facilities participating in the Louisiana Medicaid Program. Hospital based and other provider based ADHC which use Medicare forms for step down in completing their ADHC Medicaid cost reports must submit copies of the applicable Medicare cost report forms 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 facilities 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 facilities. The Medicare worksheets that must be attached by facilities using the Medicare forms for allocation are:

a. A;

b. A-6;

c. A-7 parts I, II and III;

d. A-8;

e. A-8-1;

f. B part 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 client’s arrival and departure from the facility. The attendance records should document the presence or absence of each client on each day the facility is open. The facility’s attendance records should document all admissions and discharges on the attendance records. Attendance records should be kept for all clients that attend the adult day facility. This includes Medicaid, Veteran’s Administration, insurance, private, waiver and other clients. The attendance of all clients should be documented regardless of whether a payment is received on behalf of the client. 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 client.

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;

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 client. These records shall meet the following criteria.

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

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.

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 Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2569 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2626 (September 2011), LR 41:379 (February 2015).

§2905. 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 resident assessment instrument coordinator).

4. Salaries, Social Services-gross salaries of nonsupervisory licensed social services personnel providing medically needed social services to attain or maintain the highest practicable physical, mental, or psychosocial well being of the residents.

5. Salaries, Activities―gross salaries of nonsupervisory activities/recreational personnel providing an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interest and the physical, mental, and psychosocial well being of the residents.

6. Payroll Taxes—cost of employer's portion of Federal Insurance Contribution Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Tax Act (SUTA), and Medicare tax for direct care employees.

7. Group Insurance, DC―cost of employer's contribution to employee health, life, accident and disability insurance for direct care employees.

8. Pensions, DC―cost of employer's contribution to employee pensions for direct care employees.

9. Uniform Allowance, DC―employer's cost of uniform allowance and/or uniforms for direct care employees.

10. Worker's Comp, DC―cost of worker's compensation insurance for direct care employees.

11. Contract, Aides―cost of aides through contract that are not 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 residents. This is for drugs not covered by Medicaid.

15. Medical Supplies―cost of patient-specific items of medical supplies such as catheters, syringes and sterile dressings.

16. Medical Waste Disposal―cost of medical waste disposal including storage containers and disposal costs.

17. 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 residents which are not patient-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 residents. Hospital based facilities must allocate food based on the number of meals served.

15. Food, Supplements—cost of food products given in addition to normal meals and snacks under a doctor's orders. Hospital based facilities must allocate food-supplements based on the number of meals served.

16. Supplies, CR—the costs of supplies used for rendering care related services to the clients 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 facilities 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 nonallowable 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 client 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 clients. 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 nonallowable 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. Hospital-based facilities and state-owned facilities must allocate property insurance based on the number of square feet.

5. Property Taxes—taxes levied on the center’s buildings and equipment. Hospital-based facilities and state-owned facilities must allocate property insurance based on the number of square feet.

6. Rent, Building—cost of leasing the 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 facility 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 clients to and from the center.

2. 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 personal vehicle;

b. ambulance companies; and

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

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

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

5. 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 and Hospitals, Office of Aging and Adult Services, LR 34:2166 (October 2008), repromulgated LR 34:2571 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2626 (September 2011), amended LR 41:381 (February 2015).

§2907. Allowable Costs

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 and Hospitals, Office of Aging and Adult Services, LR 34:2168 (October 2008), repromulgated LR 34:2573 (December 2008).

§2909. Nonallowable Costs

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

B. Reasonable cost does not include the following:

1. costs not related to client care;

2. costs specifically not reimbursed under the program;

3. costs that flow from the provision of luxury items or services (items or services substantially in excess or more expensive than those generally considered necessary for the provision of the care);

4. costs that are found to be substantially out of line with other centers that are similar in size, scope of services and other relevant factors;

5. costs exceeding what a prudent and cost-conscious buyer would incur to purchase the goods or services.

C. General nonallowable costs:

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

2. depreciation of non-client care assets;

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

4. goods or services unrelated to client care;

5. unreasonable costs.

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

1. advertising—costs of advertising to the general public that seeks to increase patient utilization of the ADHC center;

2. bad debts—accounts receivable that are written off as not collectible;

3. contributions—amounts donated to charitable or other organizations;

4. courtesy allowances;

5. director’s fees;

6. educational costs for clients;

7. gifts;

8. goodwill or interest (debt service) on goodwill;

9. costs of income producing items such as fund raising costs, promotional advertising, or public relations costs and other income producing items;

10. income taxes, state and federal taxes on net income levied or expected to be levied by the federal or state government;

11. insurance, officers—cost of insurance on officers and key employees of the center when the insurance is not provided to all employees;

12. judgments or settlements of any kind;

13. lobbying costs or political contributions, either directly or through a trade organization;

14. non-client 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, DHH, the Internal Revenue Service or the state Tax Commission; insufficient funds charges;

19. personal comfort items; and

20. personal use of vehicles.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2169 (October 2008), repromulgated LR 34:2573 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 41:382 (February 2015).

§2911. Audits

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 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 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 vendor 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. 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 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 client’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 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 and Hospitals, Office of Aging and Adult Services, LR 34:2169 (October 2008), repromulgated LR 34:2574 (December 2008).

§2913. Exclusions from the Database

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 and Hospitals, Office of Aging and Adult Services, LR 34:2170 (October 2008), repromulgated LR 34:2574 (December 2008).

§2915. Provider Reimbursement

A. Cost Determination Definitions

*Base Rate*—calculated in accordance with §2915.B.5, plus any base rate adjustments granted in accordance with §2915.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 client 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 §2915.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 §2915.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 §2915.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 §2915.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 §2915.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 facility specific transportation rate will be added to the facility’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 recipient 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 facilities in the most recent audited and/or desk reviewed database. If the lowest direct care per diem of all facilities 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 minimum data set home care (MDS/HC), the social assessment, the nursing assessment, the CPOC and home visits will no longer be the responsibility of the ADHC provider. Support coordination services shall be provided as a separate service covered in the ADHC waiver. As a result of the change in responsibilities, the rate paid to ADHC providers shall be adjusted accordingly.

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

1. New facilities are those entities whose beds have not previously been certified to participate, or otherwise have participated, in the Medicaid program. New facilities will be reimbursed in accordance with this Rule and receiving the direct care, care related, administrative and operating, property rate components as determined in §2915.B.1-§2915.B.6. These new facilities will also receive the state-wide average transportation rate component, as calculated in §2915.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 facilities 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 facility’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 §2903, 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 §2915.B.1-§2915.B.7. No inflation or median adjustment factor will be included in these components. The transportation component will be reimbursed as described in §2915.B.6.e.iii.

F. Effective for dates of service on or after July 1, 2012, the reimbursement rates for ADHC services shall be reduced by 1.5 percent of the rates in effect on June 30, 2012.

1. The provider-specific transportation component shall be excluded from this rate reduction.

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 Aging and Adult Services, LR 34:2170 (October 2008), repromulgated LR 34:2575 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2157 (July 2011), LR 37:2627 (September 2011), repromulgated LR 38:1594 (July 2012), amended LR 39:507 (March 2013), LR 41:382 (February 2015).