
LOUISIANA DEPARTMENT OF HEALTH
ICF/DD Cost Report Training
August 13, 2019
assurance - consulting - tax - technology - pncpa.com
Postlethwaite & Netterville, A Professional Accounting Corporation


LOUISIANA DEPARTMENT OF HEALTH
Introductions
• Andrew Perilloux, LDH Rate & Audit
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• Daryl Porta, Postlethwaite & Netterville
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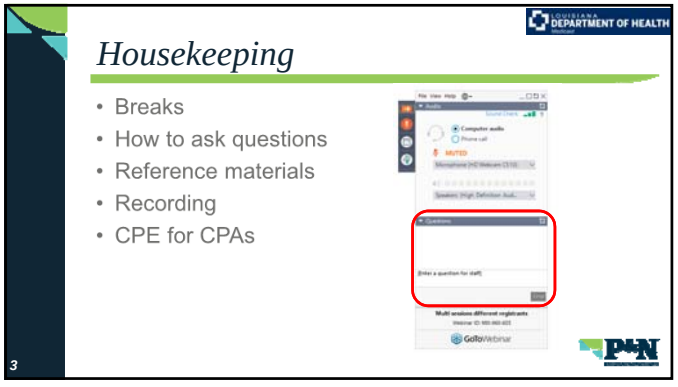
LOUISIANA DEPARTMENT OF HEALTH
Housekeeping
• Breaks
• How to ask questions
• Reference materials
• Recording
• CPE for CPAs
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Housekeeping

- This webinar qualifies for up to 4 hours of CPE
- In order to receive CPE, you must view the webinar live online and participate in the poll questions
- You will receive an evaluation survey this afternoon, and the survey must be completed by Thursday, August 15 in order to receive your CPE Certificate
- CPE Certificates will be sent Friday, August 16

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Agenda

1. Technical resources
2. Steps for completing a cost report
3. Cost report form
4. Required supporting documentation
5. Basic cost principles
6. Clients' personal funds account

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Training Objectives

- Provide information necessary to complete the Louisiana Medicaid ICF cost report
- Provide information on ICF rules and regulations
- Communicate recent changes in cost report form

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Technical Resources

- ICF/MR Standards for Payment (SFP)
  - https://www.doa.la.gov/Pages/osr/lac/books.aspx
  - Click on Title 50, Public Health – Medical Assistance
  - Pages 237 – 280 for June 2019
- LDH ICF/IID Provider Manual
  - Published on 10/1/10
  - https://www.lamedicaid.com/provweb1/Providermanuals/manuals/ICF_DD/ICF_DD.pdf
  - Click Manual Chapter

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Technical Resources

- Cost report form and instructions
  - Download from M&S every year
  - https://www.mslc.com/Louisiana/CaseMixDownloads.aspx
- Correspondence from LDH
  - Rate and Audit Unit
    - http://ldh.la.gov/index.cfm/newsroom/detail/2967
- Medicare Provider Reimbursement Manual (PRM 15)
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html
  - Click on Pub 15-1

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Why are cost reports important?

- Used to set rates
- Used to determine cost settlement, if applicable
- Used to determine compliance with LDH rules and regulations
- Used to obtain cost information for special projects or legislative requests

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How to complete a cost report

- Review the prior years' cost reports
- Review prior years' adjustments, if available
- Read the current year cost report specific instructions
- Read the current year filing submission letter from LDH
- Gather all required information
- Review general ledger for unallowable costs and classification errors

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How to complete a cost report

- Create crosswalk from general ledger in required LDH format
- Develop workpapers for Schedule I adjustments
- Complete all required allocations
- Transfer amounts from the crosswalk, workpapers and allocations to the excel template
- Check work for errors

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How to complete a cost report

- Complete provider certification page and obtain signature of authorized representative and preparer
- Submit final excel template, certification page and required supporting documents to Myers and Stauffer, LC via email at LAICF@mslc.com

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Cost report

- As-filed cost report submission includes:
  - Medicaid cost report excel template
  - Signed certification
  - Required attachments
    - Grouping schedule/crosswalk – in required format
    - Support for provider Schedule I adjustments
    - Depreciation schedule
    - Lease agreements
    - Loan agreements
- Must be submitted by 9/30 each year

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Cost report

- Schedule A – Facility Info
- Schedule B – Statistical Data
- Schedule C – Owners/Board members/Key Officers/Relatives/Related Party transactions/Leases
- Schedule D – Miscellaneous Info
- Schedule E – Staffing Pattern
- Schedule F – Balance Sheet
- Schedule G – Income Statement

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Cost report

- Schedule H – Expenses
  - Part A – Direct Care
  - Part B – Care Related
  - Part C – Administrative and Operating
  - Part D - Capital
- Schedule I – Cost report adjustments
- Schedule J – Summary of allowable costs
- Schedule K – Central office allocation
- Schedule L – Habilitation allocation

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Cost report

- Schedule N – Medicaid Direct Care Revenue Calc.
- Schedule O – Direct Care Floor Calculation
- Schedule P – Certification
- Validation Edit report
- Cover sheet with filing instructions
- Cost Report Instructions

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Cost Report

- Current version is 3.2
- Electronic submission is required
- A new excel template should be downloaded every year
- Excel template and PDF copies of attachments and certification page must be submitted to M&S
  - Submission email – LAICF@mslc.com

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Cost Report

- Use whole dollars only
- Accrual basis of accounting is required
- All records must be kept for 5 year
- Complete all sections even if response is None, N/A or $0
- Miscellaneous lines should be used only if a specific line is not available
  - Must be specified on form

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Cost report – Schedule A

- Corporate name should not be repeated on facility name line
- Street address should be for facility
- Type of Facility
  - New drop down box
    - ICF Provider
    - Home office (central office)
    - Habilitation program
- Type of control
  - New drop box

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Cost report – Schedule B

- Lines 1 & 2 – Licensed beds should agree to the facility's license
- Line 4 – Total client days available should reflect any change in licensed capacity during the year
- Line 5d – Paid bed hold days should be reported here.
  - Days when a payment is received from the client or responsible party to hold the bed when the client is not in the home
- Schedule B is modified for hab programs and is N/A for COs

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Cost report – Schedule C

- Line 1 - Related Party Disclosure
  - Should include information regarding owners, Board members, relatives, and/or key personnel
  - For non-profit providers, this means officers/board of directors/key personnel and their relatives who work for the facility (see PRM, Chapter 10)
  - Job descriptions and detailed written documentation of time worked for the persons listed on Schedule C, line1 are required as supporting documentation if allowable salary expense is reported
  - All columns should be completed
    - Use 0%, $0, or N/A as appropriate

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Cost report – Schedule C

- Line 2
  - Changes in licensure should correspond to Line 3 on Schedule B
- Line 3 – Lease information
  - Disclose all facility and vehicle leases
  - Disclose if related party

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Cost report – Schedule C

- Line 4 – Related party transactions
  - All related party transactions should be reported
    - Unless amounts are reduced to zero
  - Should include:
    - Central office allocations
    - Habilitation allocations
    - Shared costs
    - Building/vehicle actual costs if leased from related party
    - Any other transactions with related parties

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Cost report – Schedule D

- Complete all lines even if $0 or N/A
- Information reported on Schedule D should be consistent with information reported on other cost report schedules
  - Example: If vehicle lease is reported on Sch. H, part D, line 3c, then the number of vehicles leased should be reported on Sch. D, line 5

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Cost report – Schedule E

- Actual salary for each position
- Should agree to Schedule H salaries, column (a)
- Salaries should be reported on the accrual basis
- Hours per week should correspond to the salaries by line
  - Example: Direct care supervisors
  - 2 employees that work 35 hours per week
  - Avg hours/week = 70

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Cost report – Schedule F

- May present consolidated balance sheet
  - New drop down box to indicate that a consolidated balance sheet is attached in lieu of Schedule F completion
- June 30th balances from grouping schedule
  - Accrual basis
- Various lines on Schedule F have requirements to specify the type of asset or liability

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Cost report – Schedule G

- Column (a) should agree to grouping schedule
- Column (b) is used to report Sch. I adjustments
- Use lines 1a and 1b for Medicaid income received from State and client, respectively
- Specify grants and other routine service income on Lines 4a, 4b and 5
- Specify all other income on Lines 17a-17e
- All income offsets should be reported in column (b), not net in column (a)

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Cost report – Schedule H

- Column (a) should agree to grouping schedule by line items
  - Accrual Basis
  - Report all costs, even if non-allowable
- Column (b) is used to report Sch. I adjustments
  - Software will post these from Schedule I
- Must specify all other and miscellaneous accounts
  - May include an attachment with a reference to attachment on cost report

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Cost report – Schedule H

- Recent changes (LDH letter dated 8/29/18)
  - Expanded Line A14 into 3 lines
    - Line A14a – Non-legend drugs (OTC)
    - Line A14b – Prescription drugs
    - Line A14c – All other medical supplies
  - Changed line description on Line A15a to Medical equipment
    - Line A15b remains Other medical and nursing (not supplies)
  - Deleted "raw food only" from Line B8 description
    - Prepared food for clients should be reported
    - Do not include central office travel meals in Part B

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Cost report – Schedule H

- Recent changes (LDH letter dated 8/29/18)
  - Updated Line C13 to include IT services
    - Include hardware and software under capitalization limit
  - Consolidated Lines C38, C39, C40 and C41 into one line Plant Operations – Maintenance, Repairs & Supplies line C38
  - Added line C40a and C40b
    - C40a – Small equipment/furniture
    - C40b – Miscellaneous – Plant Operations
  - Combined Lines D3a and D3b into one Lease – Building line D3a

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Cost report – Schedule H

- Classifications
  - Line A15a – Medical equipment such as wheelchairs, CPAP machines, etc.
  - Line A15b – Other medical and nursing
    - Not medical supplies or drugs (see Lines A14a-c)
    - For unique medical items
  - Incontinence supplies – Line A14c

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Cost report – Schedule H

- Classifications
  - Line C37 – Contracts for outside services
    - Related to plant operations, not client care
    - Examples: Monthly pest control, lawn services
  - Line C38 – Plant operations – Maintenance, Repairs and Supplies
    - Repairs to building and equipment
      - Not vehicle repairs (Line C24)
    - Maintenance for building and equipment
    - Maintenance supplies

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Cost report – Schedule I

- Explanation should be in enough detail to describe the reason for the adjustment
  - Example:
    - Inadequate – To adjust salaries
    - Adequate – To adjust administrator salary to the LDH limit
- New – Supporting documentation for all Schedule I adjustments must be included with as-filed cost report
  - Listing of DGL accounts or CR line items is acceptable for accounts being reduced to zero
  - Offset adjustments should be included in Schedule I support
  - Computations or other support should be included

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Cost report – Schedule J

- No provider input
- Review allowable cost per day for reasonableness

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Cost report – Schedule K

- Central Office Allocation
  - Should include all programs/facilities managed by the central office/shared cost center
    - Vendor number not required for non-Medicaid programs
  - Days should be used for allocation basis **only** if all facilities are ICF/DD facilities with no habilitation facility
  - Total direct costs should be used otherwise
  - May substitute provider schedule if allocation method is more complex
    - Substitute schedule should include all the same elements as Schedule K

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Cost report – Schedule L

- Habilitation allocation
  - Should include all programs/facilities that send attendees to the habilitation program (including unrelated facilities)
  - Total attendance days for all participants should be used as the allocation basis
  - May substitute provider schedule if allocation method is more complex
  - Attendance days on Schedule L should agree to total days reported on Schedule B.

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Cost report – Schedules N and O

- Required if:
  - Complex care clients
  - Pervasive plus clients
  - Medical supply add-on clients
  - Class B survey findings
- Schedule N
  - Line 1 Pervasive plus days by level
  - Line 2 Complex care days by level
  - Line 3 Total Medicaid days by level
  - Line 6 PP/CC/MSAO revenue for cost report period

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Cost report – Schedules N and O

- Schedule O
  - No provider input required
  - Calculated preliminary amount owed to LDH, if any
  - Do not send payment with cost report

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Cost report – Schedules N and O

- Costs for PP and MSAO are required to be reported on separate lines of Schedule H, Part A (Lines 35-46)
- Complex Care costs should NOT be reported on these lines
- Days on Schedule N of the CR should agree by level of care to the provider's census records
- Revenue on Sch. N, Line 6 of the CR should agree to the Medicaid amount paid/payable to the provider

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Cost report – Schedule P

- Certification
  - Must be signed by authorized facility representative
  - Check figures on signed document must match the excel template

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Cost report – Validation edits

- To assist providers in completing all sections of the cost report

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Cost report – Required Attachments

- All required attachments must be submitted in order for the cost report to be considered complete
- Copies/scans/PDF must be legible
  - Should not be unusually small font
  - Spreadsheets should be printed with column headings and at appropriate page breaks
- Excel attachments will be accepted, but should be formatted in accordance with LDH instructions

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Cost report – Required Attachments

- Naming conventions
  - See Cover tab in excel template for naming conventions
    - Abbreviations are acceptable
    - Avoid special characters

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Cost report – Required Attachments

- Grouping schedule/crosswalk
  - Must agree to each line item on Schedules F, G and H
  - Must be sorted by cost report line item with subtotals that agree to the cost report
  - Using summations without sorting is not acceptable

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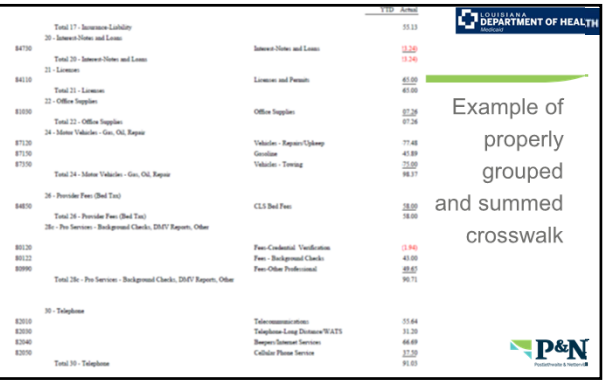

Example of properly grouped and summed crosswalk

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Group : [A]	Direct Care Costs	
Subgroup : [A-1]	Salaries - Medical (Physicians & Nurses)	
1.1	SALARY (RN)	8.00
2.1	SALARY LPN	1.85
Subtotal [A-1]	Salaries - Medical (Physicians & Nurses)	9.85
Subgroup : [A-4]	Salaries - Social Services	
3.1	SALARY- SOCIAL SERVICE	6.56
Subtotal [A-4]	Salaries - Social Services	6.56
Subgroup : [A-6]	Salaries - Therapists	
6.1	SALARY-	00.00
7.1	SALARY-	81.93
0.1	SALARY-	00.00
2.1	Staff Dev	00.00
Subtotal [A-6]	Salaries - Therapists	81.93
Subgroup : [A-7]	Salaries - Houseparents & Aides	
8.1	SALARY- SUPERVISOR	10.00
9.1	SALARY- (TRAINERS)	3.54
Subtotal [A-7]	Salaries - Houseparents & Aides	3.54

Example of properly grouped and summed crosswalk

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Cost report – Required Attachments

- Depreciation schedules should agree to Schedule H, Part D, Lines 1a to 1d
  - Must correspond to cost report period
- Loan and lease agreements should relate to the cost report period
  - Submit documentation of amendment or month-to-month agreement, if lease has expired
  - Loan agreement should include amortization schedules, if applicable

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Cost report – Required Attachments

- Schedule I adjustment supporting documentation
  - Should be attached for all adjustments
  - Should be labeled with the adjustment number that the support relates to
  - Include computational worksheets or listing of DGL transactions removed or reclassified
  - Include a listing of offset adjustments with detail of the expenses being offset

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Cost report – Required Attachments

- Schedule I adjustment supporting documentation
  - Allocation schedules are acceptable for central office and habilitation adjustments
  - Depreciation schedules are acceptable for adjustments to straight-line basis if amounts on depreciation schedule agree to column c on Sch. H, Part D

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Sch. I – Example Depreciation adj.

Allowable Depreciation
06/30/18

	GL #	Allowable	Actual	Adjustment
Buildings	#14	91.30	49.47	58.17)
Parking Lot		-	-	-
		91.30	49.47	58.17)
Equipment		19.21	-	19.21
Furniture & Fixtures		-	-	-
Transportation Equipment		-	-	-
		19.21	-	19.21
Total Depreciation		10.51	49.47	38.96)

Redacted amounts – will not foot

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Sch. I – Example Non-allowable adj

Mortgage Interest on Goodwill
June 30, 2018

Mortgage Interest on Goodwill

Bldg	52.00	59.22%
Land	30.00	3.71%
Goodwill	17.30	37.07%
	59.30	100.00%

Interest Expense 58.61
7.07% Goodwill %
87.73 Nonallowable

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Sch. I – Example Non-allowable adj.

Admin & General - Nonallowable
December 31, 2018

Description	Acct #	Total	Wkp Ref	A-8
Bad-MRB Co-Insur Not Pd by MCD	3697	152.08	-	152.08)
Resident Replacements	3077	0.00	-	-
Employee Benefits-NonAllowable	3017	954.33	-	954.33)
Legal Fees-Allowable	3021	400.00	-	400.00)
Legal Fees-NonAllowable	3022	0.00	-	-
Entertainment & Meals	3072	829.47	-	829.47)
Dues	3073	121.40	See Below	374.30)
Contributions-Charitable	3075	035.09	-	035.09)
Contributions-Political	3076	0.00	-	-
Flowers & Gifts	3077	754.25	-	754.25)
Public Relations	3078	614.12	-	614.12)
Advertising-NonAllowable	3081	790.00	-	790.00)
Barber & Beauty Shop Expense	3085	0.00	-	-
Bad Debts	3086	000.00	-	000.00)
Penalties	3088	0.00	-	-
Miscellaneous Expense	3096	0.00	-	-
Miscellaneous Expense	9000	0.00	-	-
		650.74	-	903.64)

Redacted amounts – will not foot

Redacted amounts – will not foot

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Sch. I – Example Offset adjustments

Description	GL #/ Wkp Ref	Amount	Cr Line #
Interest Income Offset		(192)	(192)
		(10)	(10)
		(202)	
Vending Machine Revenue	400		(10,183)
Offset Other Income	000	(2,139)	
	0-10		0
			0
		Dividends-	(2,139)
			0
			0
			0
			0
Activity/Craft Sales	000	0	0
Residents Personal Purchases	900	0	0
Dividend Income	101		(14,283)

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Shared Overhead/Central Office Costs

- Should be filed for all central offices and shared overhead costs
- Same form as facility, but for Type of Facility on Schedule A "Home Office" should be selected
  - Will change the form so that schedules/sections of the cost report that are N/A for central offices will have notations not to complete
- Same required attachments as facility cost report

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Shared Overhead/Central Office Costs

- Shared overhead costs should be reported on a central office cost report and allocated based on client days or direct costs
  - A central office does not have to be a separate physical location, it can be group of employees that work at one facility who provide services to other facilities
  - More than one central office cost report might be required if the shared costs are segregated by function or region
  - All entities managed must be on the allocation sch.

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Shared Costs

- Shared costs that are not central office costs
  - Must have a basis for allocation even if allocated through the monthly general ledger process
    - Dividing an invoice or salary expense by the number of facilities is not acceptable
  - Basis must relate to services provided
    - Ex: Hours for salaries, square feet for building/fixed costs, usage statistics for other variable costs
  - Costs related to central office should not be allocated to facilities through the general ledger process

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Shared Costs

- Shared direct care costs can be reported on the central office/program office cost report
  - Example 1: QMRP employee is based at CO, but spends time working directly with clients. No detail time records are kept to specifically compute salary expense related to each home. QMRP salary and related benefits/supplies can be reported on the central office cost report Sch H, Part A and allocated to facilities based on CO allocation basis.
  - Example 2: QMRP is a contractor that charges one amount for visiting all homes in a related group. Entire invoice can be reported on CO cost report
  - Example 3: QMRP contractor bills for each facility specifically. The amount related to each facility should be reported on each facility's cost report even if only one invoice is submitted and paid by the central office.

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Shared Costs

- Examples of shared costs that do not require a cost report, but do require supporting documentation
  - Building costs - Example: A habilitation program and a facility share a building. Building costs such as depreciation, property taxes and insurance, utilities should be allocated based on square feet used by each
  - Workers' compensation – Example: All workers' compensation may be paid and recorded on CO. Each facility will be allocated workers' compensation expense based on salaries

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Habilitation costs

- Habilitation services that are provided to more than one entity must be reported on a habilitation cost report
  - The costs of operating the habilitation program should not be reported directly on one of the facilities' cost report
  - Daily attendance records must be maintained for all clients
    - Including non-related facilities/waiver clients/other state programs
  - Attendance days are the only acceptable allocation basis and should be summarized by facility
  - Excel template will change when Hab program is selected

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Census Records

- Maintain accurate monthly census reports
  - Use these reports to summarize days for disclosure on Schedule B of the cost report
- Affirmative census
  - Should be performed and documented daily
  - Should be maintained by payor type
    - Also by level of care if PP/CC/MSAO
  - Should identify all occurrences (admissions, discharges, leaves) and paid bed hold days
  - Should include totals by client and by month

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Census Records

- Monitor cumulative home leave days by client
  - LDH pays for 45 home leave days per fiscal year, not to exceed 30 consecutive days in a single occurrence
  - Do not report unpaid home leave days in excess of the 45 day limit as census days on Schedule B of the cost report
- 7 hospital leave days per hospitalization
- Family/client may pay for leave days over the limits (Paid Bed Hold Day)

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Census Records

- First day of absence is the day on which the first 24 hour period of absence expires
- Only 24 continuous hours or more is considered an absence
- The client must be in the home for 24 hours for a leave to end. Otherwise, the leave continues
- The following days are not counted as home leave days:
  - Special Olympics
  - Roadrunner-sponsored events
  - Louisiana planned conferences
  - Trial discharge leaves
  - 2 Bereavement days for close relatives
  - Official state holidays – See State of La. Website
    - 2019 - https://www.doa.la.gov/Pages/osp/aboutus/2019Holidays.aspx

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Basic Cost Principles

- Provider Reimbursement Manual (PRM)
- ICF Standards for Payment
  - State specific rules
  - Refers to PRM
  - Sections 30739, 32901, 33101 and 33103 relate to cost report
  - Sections 30709-30719 relate to client fund account
- LDH ICF Provider Manual
  - State specific rules
  - Sections 26.7, 26.8 and 26.12 relate to the cost report and client fund account

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Basic Cost Principles

- Allowable cost
  - Reasonable
    - Expectation is that the provider seeks to minimize costs
    - Costs do not exceed what a prudent and cost conscious buyer would pay
    - Related to client care
  - Necessary and Proper
    - Costs to develop and maintain the operation of client care facility and activities
    - Costs which are common and accepted occurrences in field
  - Provider may buy goods or services that are not allowable, but they must be adjusted on Schedule I of the cost report
- Generally accepted accounting principles (GAAP) are required (i.e., accrual basis of accounting)

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Basic Cost Principles

- Non allowable costs
  - taxes (income, taxes related to financing and certain other taxes)
  - bad debts
  - dues to more than one professional organization
  - appraisal costs
  - collection costs
  - capital expenditures
  - directors fees (expenses may be reimbursed)
  - education costs (related to clients, not staff)
  - fines, penalties and judgments or settlements of any kind
    - NSF, late fees, parking fines, tax penalties, etc.

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Basic Cost Principles

- Non allowable costs, continued
  - payments made as gifts, etc. to parent organization
  - any cost not related to client care
  - any expense reimbursed by another program
  - vending machine expenses
  - gifts, flower and coffee shop expenses
  - donations/contributions of any nature
  - fundraising expenses
  - goodwill or other intangible asset amortization

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Basic Cost Principles

- Other costs (Allowable and Non allowable)
  - advertising is not allowable except for:
    - Employee recruiting or to solicit bids
    - Yellow pages excluding promotional ads
      - Limited to 1" by 1" size
  - interest is allowable if it is:
    - necessary for the operation of the facility & reasonably related to client care
    - proper - reasonable rate
    - interest should be reduced by interest income
    - related party interest is limited to underlying cost incurred by related party

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Basic Cost Principles

- Other costs (Allowable and Non allowable)
  - interest is not allowable if it is related to:
    - Unnecessary borrowing – PRM Section 202.2
      - No financial need
      - Transfer of excess cash to other facilities/entities
      - Significant related party receivables/non-allowable assets
    - CHOW – PRM Section 104.10 E
      - Assets can't be written up to purchase price
      - Asset basis carries over from prior owner
      - Interest on assets written up or non-allowable assets is not allowable
    - Interest rate swaps

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Basic Cost Principles

- Other costs (Allowable and Non allowable)
  - Attorney's fees are allowable only if costs are directly related to client care and not related to litigation
    - Retainers are not allowable
  - Depreciation is allowable under the following rules:
    - straight-line only
    - useful lives must follow AHA "Estimated Useful Lives of Hospital Assets" – (PM Sec. 26.12 p.8)
    - must capitalize all items with a cost of $5,000 and a useful life of at least two years

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Basic Cost Principles

- Other costs (Allowable and Non allowable) (cont'd)
  - Salary is allowable if supported by written documentation
    - Up to limits (see LDH letter dated 7/31/19)
    - LDH limits also apply to all central office and habilitation personnel as well as all owners
    - Most recent change – 1/2/18
  - In-kind contributions
    - Value of volunteer services
    - Value of donated equipment, buildings
    - See PM Sec. 26.12 page 9 and 10 for limitations on allowability

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Basic Cost Principles

- Other costs (Allowable and Non allowable) (cont'd)
  - Sitters (PM Sec. 26.8 p.11)
    - Responsibility of client/family/responsible party unless required by:
      - Hospital's policy
      - Attending physician
      - IHP
  - Self-insurance costs
    - Must comply with PRM Section 2162.7 for allowability
  - Owner's life insurance
    - Not allowable if provider is direct or indirect beneficiary

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Basic Cost Principles

- Other costs (Allowable and Non allowable)
  - Related party – Ch. 10 in PRM
    - owner's salary
      - See later slide
    - Salaries of other related parties
      - Must meet the same standards discussed on the later slide
    - rent/lease expense
      - Allowable to the extent of the underlying cost to the related party. Costs should be properly classified (i.e., depreciation should be reported on the depreciation line, interest on the interest line of the cost report, etc.)

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Basic Cost Principles

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

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Basic Cost Principles

- Other costs (Allowable and Non allowable)
  - Unrelated management fees/purchased services
    - Must comply with provisions of PRM Section 2135
  - Costs not recorded on the accrual basis
    - Cost related to prior period that should have been accrued
    - Prepaid expenses that should be amortized over life of contract/policy such as insurance

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Basic Cost Principles

- Other costs (Allowable and Non allowable)
  - Unsupported costs
    - Credit card statements and journal entries require additional support such as individual invoices or travel vouchers
  - Costs with no documented business purpose
  - Examples of required documentation:
    - Invoices
    - Contracts
    - Travel vouchers
    - Mileage logs
    - Timecards

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Basic Cost Principles

Owner's Compensation

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

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Basic Cost Principles

Owner's Compensation (cont'd)

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

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Other Facility Records

- Employee Records
  - Written verification of hours worked including date and number of hours
    - Applies to contractors or consultants
- Billing Records (Accounts Receivable)
  - Individual records for each client
    - Should detail each charge and each payment with dates and amounts
    - Be current
    - Itemize each billing entry

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Clients' Personal Funds

- Basic information re: client fund requirements can be found
  - SFP Sections 30709 through 30719
  - PM Section 26.7 pages 9 through 15

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Clients' Personal Funds

- Deficiencies identified in LDH May 20, 2015 letter
  - No specific purpose on client's ledger
  - Checks made payable to client in excess of $100
  - Checks made payable to cash or employees of facility
  - Ledger balances over resource limit of $2,000
  - No receipts for check disbursements
  - No client petty cash funds for clients

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Clients' Personal Funds

- Other common issues
  - Bank reconciliations
    - Not completed monthly
    - Not completed timely
    - Differences between sum of ledgers & reconciled bank balance
  - Deposits not made timely
  - OSS checks not transferred to client bank account within 3 business days
    - Also, do not transfer to client acct before receipt in facility acct

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Clients' Personal Funds

- Other common issues
  - Ledger sheets without required components
    - Deposits
      - Date
      - Source
      - Amount
    - Withdrawals
      - Date
      - Check #/PC voucher #
      - Payee (if check)
      - Purpose
      - Amount
    - Fund balance after each transaction

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Clients' Personal Funds

- Other common issues
  - Client liability collected in arrears
  - Petty cash disbursements posted to ledgers prior to reimbursement of petty cash account
  - Petty cash vouchers not signed
  - Missing disbursement documentation
    - If check, need cancelled check and invoice
    - If petty cash, need signed petty cash voucher
    - Client choice forms
  - Sum of receipts not agreeing to ledger disbursement

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Clients' Personal Funds

- Other common issues
  - Written policies for protection of the client account don't address all items in SFP and/or are not specific to facility
  - Client funds not returned within 30 days after discharge

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Contact information

For assistance with:		
Excel template issues and transmittal questions	Myers & Stauffer	laicf@mslc.com
Cost report extensions, rate setting and general guidance	LDH Rate & Audit	lana.ryland@la.gov
Informal review requests	LDH Rate & Audit	P.O. Box 91030 Baton Rouge, LA 70821-9030
Questions related to audit notification letters and on-going audits	P&N	dbridges@pncpa.com

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Wrap-up

- Survey
- CPE certificate will be available after survey completion
- Audit recording and PDF documents will be posted to LDH website
- Thanks!!

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P&N

Postlethwaite & Netterville

A Professional Accounting Corporation

LOUISIANA DEPARTMENT OF HEALTH

COST REPORT FOR ICF-PRIVATE AND OTHER PROGRAM PROVIDERS

Schedule A - Facility Information

COST REPORT PERIOD: FROM: July 1, 2018 TO: June 30, 2019

DATE COMPLETED: 09/15/2019

CORPORATE NAME: XYZ Corporation

FACILITY NAME: ABC Community Home

STREET ADDRESS: 123 Main Street Facility address

CITY: Baton Rouge STATE: LA ZIP: 70809 - 1111

MAILING ADDRESS: 789 Corporate Boulevard Can be central office address

MAILING CITY: Alexandria STATE: LA ZIP: 71301 - 1111

CONTACT PERSON: John Smith PHONE: (318) 555-5555 EXT:

FAX: (318) 555-4444 EXT:

E-MAIL: Jsmith@gmail.com

TYPE OF FACILITY

Type of Facility (Select Only One): ICF Provider Other: *(specify program)*

ICF Vendor Number: 77777 Vendor Number *(if applicable)*:

Other I.D. Number:

TYPE OF CONTROL (Select only one)

Non-Profit

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE B - STATISTICAL DATA

1.	Licensed Capacity at Beginning of Cost Report Period		6
2.	Licensed Capacity at End of Cost Report Period		6
3.	Effective Date of Change in Licensed Capacity, if any		na
4.	Total Client Days Available		2,190
5.	Client Days Paid and Payable at end of cost report period (a. + b. + c.)		2,150
	a. Medicaid Client Days	2,000	
	b. Other State Client Days	0	
	c. Private Client Days	150	
	d. Paid Bed Hold Days	10	
6.	Provider Fee Bed Days *(a. + b. + c. + d.)*		2,160
7.	Occupancy Percent *(Line 5 divided by Line 4)*		98.17%
8.	Clients in facility beginning of cost report period		6
9.	Admissions during cost report period		2
10.	Discharges during cost report period (include deaths)		2
11.	Clients in facility end of cost report period		6

Lines 5a thru 5c should include all days regardless of payment source or non-payment

Line 5d - Days when a payment is received from client or responsible party to hold bed during client's absence - NOT Medicaid payments

EXAMPLE OF SCHEDULE B FOR HABILITATION PROGRAMS. - THIS PAGE WILL NOT BE A PART OF THE FACILITY COST REPORT

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE B - STATISTICAL DATA

*** HABILITATION PROGRAM COST REPORT - ONLY ENTER CLIENT ATTENDANCE DAYS**

1. Client Attendance Days during the cost report period:		8,590
a.	Attendance Days - ICF/DD facilities	5,390
b.	Attendance Days - Waiver Clients	3,200
c.	Attendance Days - Other Clients	0

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE C - OWNER AND RELATED ORGANIZATION

(COST REPORT IS NOT COMPLETE WITHOUT THIS INFORMATION)

NOTE: All columns should be completed for all persons listed below. Zeroes should be reported if applicable.

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, and provide the following information:

Name	Function	% of Work Week Devoted to Business	% of Ownership	Compensation Included in Allowable Cost for This Period
John Smith	President/Adminstrator	100.00%	0.00%	0
Mary Smith	VP/Social Worker	25.00%	0.00%	5,000
Jan Doe	Board Member	0.00%	0.00%	0
Susan Jones	Board Member	0.00%	0.00%	0

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 above

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

Type of Change	From	To	Date of Change
None			

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	Monthly Payments
GMAC	None	$ 300
James Smith	John Smith's brother	1,000
John Smith	President	1,000

If building is owned by relative

If building is owned by president

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE C - OWNER AND RELATED ORGANIZATION

(COST REPORT IS NOT COMPLETE WITHOUT THIS INFORMATION)

NOTE: All columns should be completed for all persons listed below. Zeroes should be reported if applicable.

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.

RP rent: Incorrect disclosure

RP rent: Correct disclosure

Schedule H - Part	Line Item No. & Line Item Title	Amount Reported
D	3a Lease - Building	$ 12,000
D	1a Buildings	4,000
D	2 Interest - Mortgage on Building or Equipment	3,000
D	4 Property Taxes	400
D	5 Insurance - Property	150
C	33a Shared Costs (Allocated)*	31,376
D	8a Shared Costs (Allocated)*	3,469
C	33b Shared Costs (Allocated)*	15,376
D	8b Shared Costs (Allocated)*	2,654
A	18a Allocated (Related Party)	52,037

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

Name of Related Party	Name of Related Organizations	Relationship
James Smith	James Smith - Lessor	Brother of administrator
XYZ Corporation	Central Office	Common Board
XYZ Corporation	Regional Office	Common Board
Work Program, Inc.	Habilitation program	Common Owners

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE D - STAFF AND OTHER INFORMATION

1. Total number of employees for last payroll	10.0
2. Number of Minimum Wage Employees	3.0
3. Position Summary	Full Time Equivalent
a. Direct Care	7.50
b. Care Related	0.00
c. Administrative and Operating	0.00
Total Full Time Equivalent *(a. + b. + c.)*	7.50

4. Fringe Benefits Provided

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

Box will be created when drop down is selected. Should not be blank

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

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

	Original Date	Amount	Interest Rate	Amortization Period
a. First Mortgage	4/1/2015	12,000	6.00%	5
b. Second Mortgage				
c. Third Mortgage				

7. Other rates received

a. Private client rate		200.00
b. Other state or federal rates		0.00
c. Other *(specify)*		0.00
d. None		

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE E - STAFFING PATTERN

Note: List each position separately.

Avg hours per week must relate to actual salary in next column

Employee's salary exceeds DHH salary limit. Prov should make adjustment

Option 1

Position Title	Avg Hours Per Week	Actual Salary for Cost Report Period	Line Item Number (Sched. H, Part & Line)
Nurse - RN	10.00	12,500	A-1
Social Worker	10.00	45,000	A-4
Direct Care Aide	40.00	16,000	A-7
Direct Care Aide	35.00	15,000	A-7
Direct Care Aide	42.00	18,800	A-7
Direct Care Aide	40.00	16,000	A-7
Direct Care Aide	30.00	12,000	A-7
Direct Care Aide	20.00	10,000	A-7
Direct Care Aide	20.00	9,000	A-7
Direct Care Aide	35.00	15,000	A-7
Direct Care Aide	35.00	15,000	A-7
Direct Care Aide	35.00	15,000	A-7

Reflects Part-time status

Option 2

Nurse - RN	10.00	12,500	A-1
Social Worker	10.00	45,000	A-4
Direct Care Aide (10 aides)	332.00	141,800	A-7

Home Office example

CEO	40.00	120,000	C-1
CFO	40.00	110,000	C-2

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE E - STAFFING PATTERN

Note: List each position separately.

Position Title	Avg Hours Per Week	Actual Salary for Cost Report Period	Line Item Number (Sched. H, Part & Line)
VP - Human Resources	40.00	90,000	C-2
IT Director	40.00	90,000	C-5
Reimbursement Manager	40.00	80,000	C-5
Administrative Assistants (4)	160.00	80,000	C-4
	TOTAL	**$ 968,600**	

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE F - BALANCE SHEET

A combined or consolidated balance sheet for the entire agency/company is attached to the cost report: N/A

Options here are:
1. NA - complete Schedule F balances
2. Yes - leave Schedule F blank and submit a balance sheet with as-filed CR

ASSETS

ACCOUNTS	PER BOOKS
Current Assets:	
1. Cash on Hand and in Banks	20,000
2. Accounts Receivable	45,000
3. Notes Receivable	
4. Other Receivables	
5. Less: Allowance for uncollectible Accounts Receivable & Notes Receivable	
6. Inventory	
7. Prepaid Expenses	2,000
8. Investment	
9. Other *(specify)* :	
10. Total Current Assets	$ 67,000
Fixed Assets:	
11. Land	5,000
12. Buildings	
13. Less: Accumulated Depreciation	
14. Leasehold Improvements	20,000
15. Less: Accumulated Depreciation	(2,000)
16. Fixed Equipment	6,000
17. Less: Accumulated Depreciation	(500)
18. Major Movable Equipment	4,000
19. Less: Accumulated Depreciation	(3,500)
20. Motor Vehicles	40,000
21. Less: Accumulated Depreciation	(12,000)
22. Minor Equipment (non-depreciable)	
23. Total Fixed Assets	$ 57,000
Other Assets:	
24. Investments	
25. Deposits on Leases or Utilities	250
26. Due from Owners/Officers	
27. Dues to Funds	
28. Other *(specify)* :	
29. Total Other Assets	$ 250
30. TOTAL ASSETS *(sum of lines 10, 23 & 29)*	$ 124,250

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE F - BALANCE SHEET

A combined or consolidated balance sheet for the entire agency/company is attached to the cost report: N/A

LIABILITIES AND CAPITAL

ACCOUNTS		PER BOOKS
Current Liabilities		
31. Accounts Payable		35,000
32. Notes Payable		
33. Current Portion of Long-term Debt		
34. Salaries-Fees Payable		3,200
35. Payroll Taxes Payable		300
36. Deferred Income		
37. Other *(specify)* :	Accrued Bonuses	2,000
38. Total Current Liabilities		$ 40,500
Long-Term Liabilities		
39. Mortgages Payable		
40. Notes Payable		7,000
41. Unsecured Loans		
42. Loans from Owners		
43. Total Long-Term Liabilities		$ 7,000
44. TOTAL LIABILITIES *(sum of lines 38 and 43)*		$ 47,500
45. Capital		
(a) Retained Earnings		76,750
(b) Capital Stock		
(c) Other *(specify)*		
(d) Other *(specify)*		
(e) Other *(specify)*		
(f) Other *(specify)*		
(g) Other *(specify)*		
46. Total Capital		$ 76,750
47. TOTAL LIABILITIES AND CAPITAL *(sum of lines 44 and 46)*		$ 124,250

Adjustments in this column should have corresponding adjustment on Sch H

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE G - INCOME STATEMENT

		(a) Income per Books	(b) Provider Adjustments (from Schedule I)	(c) Adjusted Balance
	Routine Service Income:			
1a	Medicaid - State - Routine	375,000	-	$ 375,000
1b	Medicaid - Client Portion - Routine	25,000	-	$ 25,000
2	Other State Revenue - Routine		-	$ -
3	Private - Routine	30,000	-	$ 30,000
4a	Grants - Federal*		-	$ -
4b	Grants - State* Food	12,000	(12,000)	$ -
5	Other *(specify)*		-	$ -
6	Total Routine Service Income	442,000	(12,000)	$ 430,000
	Other Income:			
7	Special expense reimbursement (state clients)		-	$ -
8a	Donations - Restricted		-	$ -
8b	Donations - Unrestricted		-	$ -
9	Sale of Drugs		-	$ -
10	Therapy		-	$ -
11	Sale of Supplies		-	$ -
12	Employee and Guest Meals		-	$ -
13	Interest	75	(75)	$ -
14	Rentals		-	$ -
15	Beauty and Barber Shop		-	$ -
16	Vending Machine		-	$ -
17a	Miscellaneous *(specify)* Workers' comp refund	400	(400)	$ -
17b	Miscellaneous *(specify)* Copy of medical files	20	(20)	$ -
17c	Miscellaneous *(specify)*		-	$ -
17d	Miscellaneous *(specify)*		-	$ -
17e	Miscellaneous *(specify)*		-	$ -
18	Total Other Income	495	(495)	$ -
19	Total Income *(line 6 and 18)*	442,495	(12,495)	$ 430,000

Donation income and gain on sale of assets is not required to be offset

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE G - INCOME STATEMENT

		(a) Income per Books	(b) Provider Adjustments (from Schedule I)	(c) Adjusted Balance
	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)*	442,495	(12,495)	$ 430,000

*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 DHH (if any), and amount credited to personal accounts of clients, etc.

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

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE H - EXPENSES

Expense Classification		(a) Expenses per Books	(b) Provider Adjustments (from Schedule I)	(c) Allowable Expenses
A. Direct Care Costs				
1 Salaries - Medical (Physicians & Nurses)		12,500	-	$ 12,500
2 Salaries - Medical (Aides & Orderlies)			-	$ -
3 Salaries - Psychologists			-	$ -
4 Salaries - Social Services		45,000	(18,699)	$ 26,301
5 Salaries - QMRP			-	$ -
6 Salaries - Therapists			-	$ -
7 Salaries - Houseparents & Aides		141,800	-	$ 141,800
8 Salaries - Recreational - Other Employees			-	$ -
9 Payroll Taxes		18,500	(1,736)	$ 16,764
10 Employee Benefits		6,000	(563)	$ 5,437
11 Worker's Compensation		2,500	(400)	$ 2,100
12 Medical and Dental Services		600	-	$ 600
13 Medical Waste			-	$ -
14 a. Non-Legend Drugs		500	-	$ 500
b. Prescription Drugs		500	-	$ 500
c. All Other Medical Supplies	*Gloves, bandages*	200	-	$ 200
15 a. Medical Equipment			-	$ -
b. Other Medical and Nursing			-	$ -
16 Therapeutic and Training Supplies		1,000	-	$ 1,000
17 a. Shared Costs (Allocated)* (specify source)			-	$ -
17 b. Shared Costs (Allocated)* (specify source)			-	$ -
17 c. Shared Costs (Allocated)* (specify source)			-	$ -
18 Habilitation (Day Program)				
a. Allocated (Related Party)			52,037	$ 52,037
b. Contracted (Unrelated)		25,000	-	$ 25,000

Incontinence supplies and enterals

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE H - EXPENSES

Expense Classification		(a) Expenses per Books	(b) Provider Adjustments (from Schedule I)	(c) Allowable Expenses
19 a. Other - Therapeutic and Training			-	$ -
b. Other - Therapeutic and Training			-	$ -
20 Recreational Supplies		250	-	$ 250
21 a. Miscellaneous - Recreational		1,250	-	$ 1,250
b. Miscellaneous - Recreational		100	-	$ 100
22 Contract - Nursing			-	$ -
23 Contract - Social Worker (MSW)			-	$ -
24 Contract - QMRP			-	$ -
25 Contract - Pharmacist		1,200	-	$ 1,200
26 Contract - Psychiatrist			-	$ -
27 Contract - Psychologist		3,200	-	$ 3,200
28 Contract - Physician		1,000	-	$ 1,000
29 Contract - Physical Therapis			-	$ -
30 Contract - Speech Therapist			-	$ -
31 Contract - Audiologist		500	-	$ 500
32 Contract - Recreational			-	$ -
33 Contract - Records Librarian			-	$ -
34 Contract - Other	*Dentist consultant*	500	-	$ 500
Pervasive Plus Expenses				
35 PERVASIVE PLUS - Medical Staff (RNs and LPNs) Salaries			-	$ -
36 PERVASIVE PLUS - Medical Staff Payroll Tax			-	$ -
37 PERVASIVE PLUS - Medical Staff Employee Benefits			-	$ -
38 PERVASIVE PLUS - Medical Staff Workmen's Comp			-	$ -
39 PERVASIVE PLUS - Direct Care Worker Salaries			-	$ -
40 PERVASIVE PLUS - Direct Care Worker Payroll Tax			-	$ -
41 PERVASIVE PLUS - Direct Care Worker Employee Benefits			-	$ -
42 PERVASIVE PLUS - Direct Care Worker Workman's Comp			-	$ -
43 PERVASIVE PLUS - Medical Services			-	$ -
44 PERVASIVE PLUS - Medical Supplies			-	$ -
45 PERVASIVE PLUS - Habilitation (Day Program)			-	$ -
Medical Supply Add-On Expenses				
46 Medical Supply Add-On - Medical Supplies			-	$ -
Total Direct Care Costs		**262,100**	**30,639**	**$ 292,739**

*Use this line to show this facility's share of allocated or shared cost in the Direct Care Cost area. A separate central office cost report must be provided with an allocation schedule and the method and percentage of allocation.

(carry to Schedule J, Column (a), Line (A))

Should not include routine medical care or salaried personnel

Only consultants here - not client routine services

Must keep separate records for PP and Med Supply Add-on costs

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE H - EXPENSES

Expense Classification		(a) Expenses per Books	(b) Provider Adjustments (from Schedule I)	(c) Allowable Expenses
B. Care Related Costs				
1 Salaries - Food Service Supervisor			-	$ -
2 Salaries - Cooks (Chief/Asst.)			-	$ -
3 Salaries - Kitchen Helpers			-	$ -
4 Salaries - Activity Director			-	$ -
5 Payroll Taxes			-	$ -
6 Employee Benefits			-	$ -
7 Worker's Compensation			-	$ -
8 Food	Prepared/purchased client meals and supplements	10,000	(12,000)	$ (2,000)
9 Supplies (Dishes, Flatware, Napkins, Utensils, etc.)		1,000	-	$ 1,000
10 Contract For Outside Services - Dietician/Nutritionist		600	-	$ 600
11 Contract For Outside Services - Other Dietary			-	$ -
12 a. Miscellaneous - Dietary			-	$ -
b. Miscellaneous - Dietary			-	$ -
13 Educational Expense			-	$ -
14 Personal Client Needs - Clothing		1,200	-	$ 1,200
15 a. Personal Client Needs - Other	*Haircuts*	500	-	$ 500
b. Personal Client Needs - Other	*Hygeine supplies*	1,100	-	$ 1,100
16 a. Shared Costs (Allocated)* (specify source)			-	$ -
16 b. Shared Costs (Allocated)* (specify source)			-	$ -
16 c. Shared Costs (Allocated)* (specify source)			-	$ -
Total Care Related Costs		**14,400**	**(12,000)**	**$ 2,400**

*Use this line to show this facility's share of allocated or shared cost in the Care Related Cost area. A separate central office cost report must be provided with an allocation schedule and the method and percentage of allocation.

(carry to Schedule J, Column (a), Line (B))

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

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		-	$ -
2 Salaries and Wages - Asst Administrator		-	$ -
3 Salaries and Wages - Owner - If not Administrator	100,000	(100,000)	$ -
4 Salaries and Wages - Clerical		-	$ -
5 Salaries and Wages - Other		-	$ -
6 Salaries and Wages - Plant Operation and Maintenance		-	$ -
7 Salaries and Wages - Laundry and Linen		-	$ -
8 Salaries and Wages - Housekeeping		-	$ -
9 Payroll Taxes		-	$ -
10 Employee Benefits (Health Insurance etc.)		-	$ -
11 Advertising and Promotion	1,500	(1,000)	$ 500
12 Bad Debts		-	$ -
13 Data Processing and IT Services *Payroll processing, new computer*	500	-	$ 500
14 Dues (Only 1 Organization Allowed)		-	$ -
15 Insurance - Officer's Life (Provide copy of Policy)		-	$ -
16 Insurance - Worker's Compensation		-	$ -
17 Insurance - Liability	1,400	-	$ 1,400
18 Insurance - Malpractice	800	-	$ 800
19 Other Insurance		-	$ -
20 Interest (Other Than Capital Assets)		-	$ -
21 Licenses	600	-	$ 600
22 Office Supplies	900	-	$ 900
23 Printing	250	-	$ 250
24 Motor Vehicles - Gas, Oil, Repair	4,500	-	$ 4,500
25 Taxes - Non-Property		-	$ -
26 Provider Fees (Bed Tax)	30,745	-	$ 30,745
27 Postage		-	$ -
28 Professional Services			
a. Accounting	1,500	(1,000)	$ 500
b. Legal	300	(300)	$ -
c. Other		-	$ -
29 Subscriptions	400	-	$ 400
30 Telephone	2,200	-	$ 2,200

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE H - EXPENSES

Expense Classification		(a) Expenses per Books	(b) Provider Adjustments (from Schedule I)	(c) Allowable Expenses
31 Training, In-Service (Supplies and Expense)		750	-	$ 750
32 Travel and Seminar Expenses		800	-	$ 800
33 a. Shared Costs (Allocated)* (specify source)	*Central Office*		24,657	$ 24,657
33 b. Shared Costs (Allocated)* (specify source)	*Regional Office*		15,376	$ 15,376
33 c. Shared Costs (Allocated)* (specify source)			-	$ -
34 Miscellaneous - Director's Fees			-	$ -
35 Miscellaneous - Management Fees			-	$ -
36 a. Miscellaneous - Other Administrative	*Background checks*	450	(20)	$ 430
b. Miscellaneous - Other Administrative			-	$ -
c. Miscellaneous - Other Administrative			-	$ -
d. Miscellaneous - Other Administrative			-	$ -
37 Contracts For Outside Services - Plant Operation and Maintenance		2,400	-	$ 2,400
38 Plant Operations - Maintenance, Repairs and Supplies		2,050	-	$ 2,050
39 Utilities (Fuel, Gas, Water, Electricity)		8,600	-	$ 8,600
40 a. Small Equipment/Furniture			-	$ -
b. Miscellaneous - Plant Operation & Maint.			-	$ -
41 Supplies - Laundry & Linen		700	-	$ 700
42 Linen & Bedding		200	-	$ 200
43 Contracts For Outside Services - Laundry & Linen			-	$ -
44 a. Miscellaneous - Laundry			-	$ -
b. Miscellaneous - Laundry			-	$ -
45 Supplies - Housekeeping		1,700	-	$ 1,700
46 Contracts For Outside Services - Housekeeping			-	$ -
47 a. Miscellaneous - Housekeeping			-	$ -
b. Miscellaneous - Housekeeping			-	$ -
Total Administrative and Operating Costs		**163,245**	**(62,287)**	**$ 100,958**

*Use this line to show this facility's share of allocated or shared cost in the Admin. & Operating Cost area. A separate central office cost report must be provided with an allocation schedule and the method and percentage of allocation.

(carry to Schedule J, Column (a), Line (C))

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE H - EXPENSES

Expense Classification		(a) Expenses per Books	(b) Provider Adjustments (from Schedule I)	(c) Allowable Expenses
D. Capital Asset Costs				
1 Depreciation *(Provide Detailed Schedules)*				
a. Buildings		0	4,000	$ 4,000
b. Furniture & Equipment		500	-	$ 500
c. Motor Vehicles		5,000	-	$ 5,000
d. Leasehold Improvements		500	-	$ 500
2 Interest - Mortgage on Building or Equipment			2,925	$ 2,925
3 Leases *(Provide Copy)*				
a. Lease - Building		12,000	(12,000)	$ -
b. Lease - Furniture & Equipment			-	$ -
c. Lease - Motor Vehicles			-	$ -
4 Property Taxes			1,500	$ 1,500
5 Insurance - Property			400	$ 400
6 Insurance - Motor Vehicles		2,100	-	$ 2,100
7 a. Other - Capital Assets			-	$ -
b. Other - Capital Assets			-	$ -
8 a. Shared Costs (Allocated)* (specify source)	*Central Office*		2,716	$ 2,716
8 b. Shared Costs (Allocated)* (specify source)	*Regional Office*		2,654	$ 2,654
8 c. Shared Costs (Allocated)* (specify source)			-	$ -
Total Capital Assets Costs		**20,100**	**2,195**	**$ 22,295**
Sum of Sections A, B, C and D		**459,845**	**(41,453)**	**$ 418,392**

*Use this line to show this facility's share of allocated or shared cost in the Capital Cost area. A separate central office cost report must be provided with an allocation schedule and the method and percentage of allocation.

(carry to Schedule J, Column (a), Line (D))

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE I - EXPLANATION FOR ADJUSTMENTS

Adj.	Schedule	Part	Line	Column	Explanation for Adjustment	Provider Adjustment
1	G - Income Stmt		4b Grants - State*	Total	To offset food grant income	(12,000)
1	H - Expenses	B	8 Food	Total	To offset food grant income	(12,000)
2	G - Income Stmt		13 Interest	Total	To offset interest income	(75)
2	H - Expenses	D	2 Interest - Mortgage on Building or Equipment	Total	To offset interest income	(75)
3	G - Income Stmt		17a Miscellaneous (specify)	Total	To offset workers' comp refunds	(400)
3	H - Expenses	A	11 Worker's Compensation	Total	To offset workers' comp refunds	(400)
4	G - Income Stmt		17b Miscellaneous (specify)	Total	To offset copy revenue	(20)
4	H - Expenses	C	36a Miscellaneous - Other Administrative	Total	To offset copy revenue	(20)
5	H - Expenses	A	4 Salaries - Social Services	Total	To adjust the social worker's salary to LDH limit	(18,699)
5	H - Expenses	A	9 Payroll Taxes	Total	To adjust payroll taxes related to salaries in excess of LDH limit	(1,736)
5	H - Expenses	A	10 Employee Benefits	Total	To adjust employee benefits related to salaries in excess of LDH limit	(563)
6	H - Expenses	C	3 Salaries and Wages - Owner - If not Administrator	Total	To remove compensation not related to client care	(100,000)
7	H - Expenses	C	28b Legal	Total	To remove legal fees related to dispute over control of facility	(300)
8	H - Expenses	C	28a Accounting	Total	To remove accounting fees related to personal tax return of administrator	(1,000)
9	H - Expenses	C	11 Advertising and Promotion	Total	To remove marketing and promotional advertsing costs	(1,000)
10	H - Expenses	D	3a Lease - Building	Total	To remove related party rent	(12,000)
10	H - Expenses	D	1a Buildings	Total	To add actual building expense incurred by related party	4,000
10	H - Expenses	D	2 Interest - Mortgage on Building or Equipment	Total	To add actual building expense incurred by related party	3,000
10	H - Expenses	D	4 Property Taxes	Total	To add actual building expense incurred by related party	1,500
10	H - Expenses	D	5 Insurance - Property	Total	To add actual building expense incurred by related party	400
11	H - Expenses	C	33a Shared Costs (Allocated)*	Total	To report central office allocation	24,657
11	H - Expenses	D	8a Shared Costs (Allocated)*	Total	To report central office allocation	2,716
11	H - Expenses	C	33b Shared Costs (Allocated)*	Total	To report regional office allocation	15,376
11	H - Expenses	D	8b Shared Costs (Allocated)*	Total	To report regional office allocation	2,654
11	H - Expenses	A	18a Allocated (Related Party)	Total	To report habilitation allocation	52,037

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE I - EXPLANATION FOR ADJUSTMENTS

Adj.	Schedule	Part	Line	Column	Explanation for Adjustment	Provider Adjustment

INCOME TOTALS	**$ (12,495)**
EXPENSE TOTALS	**$ (41,453)**
GRAND TOTALS (Includes Statistics)	**(53,948)**

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE J - CALCULATION OF COSTS PER DAY BY CATEGORY

Expense Classification	Allowable Expenses (a)	Divided by Total Client Days (b)	Allowable Cost per Day (c)
A. Direct Care Costs	292,739 (from Schedule H, Part A, Total)	2,150 (from Sched. B, #5 Total)	$ 136.16 (Column a Divided by b)
B. Care Related Costs	2,400 (from Schedule H, Part B, Total)	2,150 (from Sched. B, #5 Total)	$ 1.12 (Column a Divided by b)
C. Administrative and Operating Costs	100,958 (from Schedule H, Part C, Total)	2,150 (from Sched. B, #5 Total)	$ 46.96 (Column a Divided by b)
D. Capital Assets Costs	22,295 (from Schedule H, Part C, Total)	2,150 (from Sched. B, #5 Total)	$ 10.37 (Column a Divided by b)
Total Allowable Costs	$ 418,392		
Total Allowable Costs per Day			$ 194.61

Cost should be actual cost per general ledger before any cost report adjustments and excluding related party allocations

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

NOTE: For Central Offices: Complete all columns. Include all facilities/programs managed by the central office.
NOTE: For ICF and Habilitation Facilities: Attach a copy of the Central Office Schedule G.

SCHEDULE K - CENTRAL OFFICE ALLOCATION METHOD

Vendor Number (a)	Facility/Program Name (b)	Allocation Basis (cost or days) (c)	Allocation % (d)	Direct Care Allocation Amount (e)	Care Related Allocation Amount (f)	Admin & Operating Allocation Amount (g)	Capital Assets Allocation Amount (h)
77777	ABC Community Home	459,845	12.345300%	$ 36,140	$ 296	$ 12,464	$ 2,752
71111	DEF Community Home	512,000	13.745500%	$ 40,238	$ 330	$ 13,877	$ 3,065
72222	123 Community Home	487,000	13.074400%	$ 38,274	$ 314	$ 13,200	$ 2,915
73333	456 Community Home	601,000	16.134900%	$ 47,233	$ 387	$ 16,289	$ 3,597
	Waiver Program	65,000	1.745000%	$ 5,108	$ 42	$ 1,762	$ 389
	SIL Program	1,250,000	33.558400%	$ 98,239	$ 805	$ 33,880	$ 7,482
	Habilitation Program	350,000	9.396400%	$ 27,507	$ 226	$ 9,486	$ 2,095
			0.000000%	$ -	$ -	$ -	$ -
			0.000000%	$ -	$ -	$ -	$ -
			0.000000%	$ -	$ -	$ -	$ -
			0.000000%	$ -	$ -	$ -	$ -
			0.000000%	$ -	$ -	$ -	$ -
			0.000000%	$ -	$ -	$ -	$ -
			0.000000%	$ -	$ -	$ -	$ -
			0.000000%	$ -	$ -	$ -	$ -
			0.000000%	$ -	$ -	$ -	$ -
			0.000000%	$ -	$ -	$ -	$ -
			0.000000%	$ -	$ -	$ -	$ -
			0.000000%	$ -	$ -	$ -	$ -
			0.000000%	$ -	$ -	$ -	$ -
			0.000000%	$ -	$ -	$ -	$ -
			0.000000%	$ -	$ -	$ -	$ -
	TOTALS	3,724,845	99.999900%	$ 292,739	$ 2,400	$ 100,958	$ 22,295

Must include all programs that received services from the central office

Source: Schedule J of Central Office cost report

Source: Habilitation attendance records

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

NOTE: For Habilitation (Day Program) Facilities: Complete all columns. Include all clients that attend the habilitation program by facility.
NOTE: For ICF Facilities: Attach a copy of the Habilitation Facility Schedule.

SCHEDULE L - HABILITATION PROGRAM ALLOCATION METHOD

Vendor Number (a)	Facility/Program Name (b)	Attendance Days (c)	Allocation % (d)	Allocation Amount (e)
77777	ABC Community Home	1,490	17.345800%	$ 52,037
71111	DEF Community Home	1,650	19.208400%	$ 57,625
72222	123 Community Home	800	9.313200%	$ 27,940
73333	456 Community Home	1,450	16.880100%	$ 50,640
	SIL	3,200	37.252600%	$ 111,758
			0.000000%	$ -
			0.000000%	$ -
			0.000000%	$ -
			0.000000%	$ -
			0.000000%	$ -
			0.000000%	$ -
			0.000000%	$ -
			0.000000%	$ -
			0.000000%	$ -
			0.000000%	$ -
			0.000000%	$ -
			0.000000%	$ -
			0.000000%	$ -
			0.000000%	$ -
			0.000000%	$ -
			0.000000%	$ -
			0.000000%	$ -
			0.000000%	$ -
	TOTAL	8,590	100.000100%	300,000

Must include all entities that send clients to habilitation program even if unrelated to the group

Total days should agree to total days reported on Schedule B of the habilitation cost report

Source: Schedule J of Habilitation cost report

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE N - Medicaid Direct Care Revenue Calculation

As Submitted by Provider

Provider Filing Note: Providers must indicate a "Yes" or "No" response to each of the below four questions. If you are unsure of the appropriate response to any of the questions, please contact LDH at (225) 342-6116 for additional assistance.

1	Did the facility receive any Pervasive Plus payments in this cost report period?	No
2	Did the facility receive any Medical Supply Add-On payments in this cost report period?	No
3	Did the facility receive any Class B survey findings in this cost report period?	No
4	Did the facility receive any Complex Care payments in this cost report period?	No

If the answer to Questions 1, 2, 3, or 4 is "YES", the facility must complete this schedule.

Part A 1-8 Beds Census

	Intermittent	Limited	Extensive	Pervasive	Total
1. Pervasive Plus Days by Level					-
2. Complex Care Days by Level					-
3. Total Medicaid Days by Level					-
4. Direct Care Rate Component	$95.16	$104.09	$119.28	$135.36	
5. Total Direct Care Revenue	$ -	$ -	$ -	$ -	$ -
6. Pervasive Plus / Complex Care / Medical Supply Add-On Revenue					
7. Total Medicaid Direct Care Revenue					$ -

Part B 9-15 Beds Census

1. Pervasive Plus Days by Level					-
2. Complex Care Days by Level					-
3. Total Medicaid Days by Level					-
4. Direct Care Rate Component	$90.11	$98.60	$113.02	$128.31	
5. Total Direct Care Revenue	$ -	$ -	$ -	$ -	-
6. Pervasive Plus / Complex Care / Medical Supply Add-On Revenue					
7. Total Medicaid Direct Care Revenue					$ -

Part C 16-32 Beds Census

1. Pervasive Plus Days by Level					-
2. Complex Care Days by Level					-
3. Total Medicaid Days by Level					-
4. Direct Care Rate Component	$79.73	$87.81	$101.51	$116.03	
5. Total Direct Care Revenue	$ -	$ -	$ -	$ -	-
6. Pervasive Plus / Complex Care / Medical Supply Add-On Revenue					
7. Total Medicaid Direct Care Revenue					$ -

Part D 33+ Beds Census

1. Pervasive Plus Days by Level					-
2. Complex Care Days by Level					-
3. Total Medicaid Days by Level					-
4. Direct Care Rate Component	$68.81	$75.63	$87.27	$99.59	
5. Total Direct Care Revenue	$ -	$ -	$ -	$ -	-
6. Pervasive Plus / Complex Care / Medical Supply Add-On Revenue					
7. Total Medicaid Direct Care Revenue					$ -

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE O - Direct Care Floor Limitation Calculation

Provider Filing Note: A facility wide Direct Care floor may be enforced upon deficiencies related to Direct Care staffing requirements noted during the HSS annual review or during a complaint investigation in accordance with LAC 50:I.5501 et seq. or if the provider received Pervasive Plus or Complex Care payments during the cost report period.

A	DIRECT CARE REVENUE		
1	Medicaid Direct Care Revenue *(Schedule N)*	$	-
2	Less: Pervasive Plus / Complex Care / Medical Supply Add-On Revenue *(Schedule N)*		-
3	Non-Pervasive Plus / Complex Care / Medical Supply Add-On Revenue *(line A1 less line A2)*	$	-
4	Floor		94%
5	94% of Non-Pervasive Plus / Complex Care / Medical Supply Add-On Medicaid Direct Care Revenue (line A3 times line A4)	$	-
6	Add: Pervasive Plus / Complex Care / Medical Supply Add-On Revenue *(Schedule N)*	$	-
7	Direct Care Floor *(line A5 plus line A6)*	$	-

B	DIRECT CARE COST		
1	Medicaid Days *(Schedule B, line 5a)*		-
2	Direct Care Cost per Day *(Schedule J, line A, column c)*	$	-
3	Total Medicaid Direct Care Cost *(line B1 times B2)*	$	-
C	Medicaid Direct Costs below the Direct Care Floor (line A7 less line B3, if less than $0, enter $0)	$	-

If Line C is greater than $0, Complete D and E below

D	LIMITATION		
1	Total Medicaid revenue *(Schedule G, Income Statement, lines 3a & 3b less line 24)*	$	-
2	a Medicaid Days *(Schedule B, Line 5a)*		-
	b Total Cost Per Day *(Schedule J)*	$	-
	c Total Medicaid Cost *(line D2a times D2b)*	$	-
3	Factor		104%
4	104% of total Medicaid costs	$	-
5	Excess of total Medicaid revenues over 104% of Medicaid costs *(line D1 less line D4, if less than $0, enter $0)*	$	-

E	AMOUNT DUE TO STATE, if floor is applicable *(lower of line C or line D5)*	$	-

NOTE: If calculation shows money due to the Louisiana Department of Health, do not remit payment with the cost report. Provider will be notified of amount due after desk review/audit.

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

SCHEDULE P - Certification Statement by Preparer and Owner, Officer, or Administrator of Facility

I, John Smith (Name), Administrator (Administrative Title)

of ABC Community Home (Name of Facility)

Alexandria (City), LA (State) do certify that I have examined the attached report for the cost report period beginning 7/1/2018 and ending 6/30/2019 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

Title

Total Provider Fee Bed Days:		2,160	Total Medicaid Direct Care Revenue:	$	-
Total Allowable Expenses:	$	418,392	Amount Due To State (if floor is applicable)	$	-

Comments:

Signature of Preparer

Date

Name of Preparer

VENDOR NUMBER: 77777
FACILITY NAME: ABC Community Home
COST REPORT PERIOD: 7/1/2018 TO 6/30/2019

Validation Edits

Comparison #1		Comparison #2		Difference
Total Assets *(Sched. F - Balance Sheet, Line 30)*	$ 124,250	Total Liabilities & Capital *(Sched. F - Balance Sheet, Line 47)*	$ 124,250	**$ -**
Clients in Facility (EOP) *(Sched. B - Stats, Line 11)*	N/A	Licensed Capacity (EOP) *(Sched. B - Stats, Line 2)*	N/A	
Medicaid Days by Level *(Sched. N - DC Revenue, Line 2 sum)*	N/A	Medicaid Client Days *(Sched. B - Stats, Line 5a)*	N/A	
Educational Expenses Amount Inputed *(Sched. H - Expenses, Pt. B, Line 13, Column a)*	$ -	Educational Expenses Adjustment Amount *(Sched. H - Expenses, Pt. B, Line 13, Columns b & c)*	$ -	**$ -**
Bad Debts Amount Inputed *(Sched. H - Expenses, Pt. C, Line 12, Column a)*	$ -	Bad Debts Adjustment Amount *(Sched. H - Expenses, Pt. C, Line 12, Columns b & c)*	$ -	**$ -**
Director's Fees Amount Inputed *(Sched. H - Expenses, Pt. C, Line 34, Column a)*	$ -	Director's Fees Adjustment Amount *(Sched. H - Expenses, Pt. C, Line 34, Columns b & c)*	$ -	**$ -**
Total Client Adjustments Posted	$ (53,948)	Total Client Adjustments Entered	$ (53,948)	**$ -**
Total DHH Adjustments Posted	$ -	Total DHH Adjustments Entered	$ -	**$ -**
Questions on Schedules N				
Schedule N Properly Completed (Days / Revenue Reported When Questions are Answered Yes)				
Schedule A Completed				
Schedule B Completed				
Schedule C Completed				
Schedule D Completed				

**Amounts in Difference column should be zero or blank.

State of Louisiana
Department of Health and Hospitals
ICF-Private Cost Report

INSTRUCTIONS FOR FILING:

I **Within 90 days of cost report period end,** e-mail the following documentation to Myers and Stauffer.

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")

ICF-Private Documentation

1. Signed and dated Certification Page of the Louisiana Medicaid ICF-Private Cost Report
2. Electronic copy of completed Louisiana Medicaid ICF-Private cost report in Excel.
3. Grouping Schedule/Crosswalk that agrees to Schedules F, G and H by cost report line item (must include general ledger accounts by account number and subtotals for each cost report line)
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 ICF-Private Central Office Cost Report.
7. Electronic copy of completed Louisiana Medicaid ICF-Private cost report in Excel.
8. Grouping Schedule/Crosswalk that agrees to Schedules F, G and H by cost report line item (must include general ledger accounts by account number and subtotals for each cost report line).
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*)
11. Supporting Documentation for Schedule I Adjustments

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 electronic documentation should be e-mailed to Myers and Stauffer at:

LAICF@mslc.com

All paper documentation can be mailed (using certified or other traceable delivery) or faxed to:

Myers and Stauffer
ATTN: Louisiana ICF-Private
700 W. 47th Street, Suite 1100
Kansas City, Missouri 64112
Fax: (816) 945-5301
Phone: (800) 374-6858

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 ICF-Private Cost Report Template Instructions

ICF-Private Version 3.2 07/18/2019

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 later versions (Office 2016/365), 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 and Later Versions:

You can change macro security settings in the Trust Center, unless a system administrator in your organization has changed the defaul 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, central allocation, habilitation, 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 J, N and C 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 ICF Standards for Payment and the Federal entries Provider Reimbursement Manual (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 Provider Reimbursement Manual (CMS Publication 15) go to the following web-site

https://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

Identifying Information

Report in the spaces provided the corporate and facility name, street address, mailing address if different from street address, Title XIX vendor number and cost report period. The name, telephone number and email address 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

Statistical Information

The provider must maintain daily affirmative census records by payor type. The census should have totals by resident for each month and monthly totals. The sum of the totals for each month should agree to the days reported on the cost report. For habilitation facilities the attendance days should be maintained by facility and by payor and should reconcile to the total reported on the cost repor

Statistical and Other Data

1 Enter total licensed capacity at beginning of the period

2 Enter total licensed capacity at end of the period.

3 Enter effective date of change in licensed capacity, if applicable.

4 Enter client days available (licensed capacity times days the facility was open for the period).

5 Enter the client days in the appropriate category. Enter total as sum of a, b, and c.

6 Enter total provider fee days (sum of a, b, c and d).

7 Enter percent of occupancy (line 5 divided by line 4)

8 Enter number of clients in facility at the beginning of the period.

9 Enter number of admissions during the period.

10 Enter number of total discharges and deaths during the period.

11 Enter number of clients in facility at the end of the period (sum of line 8, 9, 10).

Schedule C

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 or any equipment is leased, give name of owner of each leased asset, relationship to the facility, and terms of the lease A copy of lease 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 (HIM-15), complete sections a. and b. Home office and habilitation allocations should be included as related party transactions for facilities.

Schedule D

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 number of full time equivalent (total hours for the year divided by 2080). Indicate total full time equivalent as the sum of lines a, b and c.

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, interest rate and term of each mortgage

7 Indicate other non-Medicaid rates received during the cost report period.

Schedule E

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-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

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 6 and any miscellaneous income reported on Line 19 should be specified.

Schedule H

Direct Care Costs – Part A

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 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 Schedule J, Line A, column (a).

Care Related Costs – Part B

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 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 Schedule J, Line B, column (a).

Administrative and Operating Costs – Part C

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 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 Schedule J, Line C, column (a).

Property and Equipment – Part D

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 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 Schedule J, Line D, column (a).

A copy of the depreciation schedule must be attached which agrees to reported depreciation expense.

Schedule I

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 transactior adjustments to actual cost.

The following items are specifically non-allowable expenses

If you enter amounts in one of these fields, **you must adjust the row to a zero balance**.

Schedule H, Part B, Line 12 - Educational Expense

Schedule H, Part C, Line 12 - Bad Debts Expense

Schedule H, Part C, Line 34 - Miscellaneous - Director's Fees

Schedule J

Calculation of Costs Per Day by Category

Divide Column (a) (Allowable Expenses) by Column (b) (Total client days reported on Schedule B.) to calculate Column (c) Allowabl Cost Per Day for each category. Enter the sum of Lines A, B, C, and D in column (c) for Total Allowable Cost per Day.

Schedule K

Central Office Allocation Method

All programs (Medicaid or non-Medicaid) managed/owned by the central office should be included in the allocation schedule. Days or costs may be used as the allocation basis if all programs are ICF programs. If other programs are included (such as a habilitatior program, waiver program, etc), then costs should be used. Costs used for allocation purposes should be direct costs Direct costs are defined as per book costs (Schedule H, column a) less any home office allocation or related party management fees included in column a.

In preparing schedule K, enter the first three columns in each necessary facility row

Then, enter the four amounts at the bottom of the page (direct, care, admin, and capital)

Schedule L

Habilitation Allocation Method

All clients (Medicaid or non-Medicaid) participating in the habilitation program should be included in the allocation schedule. Attendance days should be used as the allocation basis. Client attendance days should be grouped by facility to compute the allocatior amount for each facility. Enter amounts in columns (a) – (c) and the total in column (e)

Schedule M

Not used for years ending on/after 6/30/09.

Schedule N

Providers must indicate a "Yes" or "No" response to each of the four questions listed. If you are unsure of the appropriate response please contact LDH at (225) 342-6116 for additional assistance.

Medicaid Direct Care Revenue Calculation

1 Enter Pervasive Plus days during the period by level (Source: Provider's records)

2 Enter Complex Care days during the period by level (Source: Provider's records)

3 Enter Total Medicaid Days by level including Pervasive Plus days (Source: Provider's records)

4 Enter the Direct Care Rate Component on line 3

5 Multiply line 2 times line 3

6 Input total Pervasive Plus / Complex Care / Medical Supply Add-On Revenue on Line 5 (Source: Provider's records)

7 Add lines 4 and 5 to compute Total Medicaid Direct Care Revenue (line 6). This revenue should be carried to Schedule O fo the Direct Care floor calculation.

Schedule O

A facility wide Direct Care floor may be enforced upon deficiencies related to Direct Care staffing requirements noted during the HSS annual review or during a complaint investigation in accordance with LAC 50:I.5501 et seq. or if the provider received Pervasive Plu or Complex Care payments during the cost report period

Direct Care Revenue – Part A

1 Enter Medicaid Direct Care Revenue calculated on Schedule N, Line 6

2 Enter Pervasive Plus / Complex Care / Medical Supply Add-On Revenue from Schedule N, Line 5

3 Subtract Line A2 from Line A1

4 Multiply Line A3 times A4

5 Enter Pervasive Plus / Complex Care / Medical Supply Add-On Revenue from Schedule N, Line 5

6 Add Line A5 and Line A6 to compute the total Medicaid Direct Care Floor

Direct Care Costs – Part B

1 Input Medicaid days from Schedule B, line 5a on Line B1

2 Input Direct Care Cost per day from Line A on Schedule J, Column C

3 Calculate Total Direct Care Cost by multiplying Line B1 times B2

Part C - Calculate the Medicaid Direct Care Costs below the Direct Care Floor by subtracting Line B3 from Line A7.
If less than zero, enter zero.

Part D - Limitation on Direct Care Floor Amount Due

1 Input net Medicaid income from Income Statement, Schedule G (lines 3a & 3b less line 24)

2a Input Medicaid days from Schedule B, line 5a

2b Input Total Cost per day from Schedule F on Line D2b

2c Calculate Total Medicaid Cost by multiplying Line D2a times D2b

4 Multiply Line D2c times Line D3

5 Subtract Line D4 from Line D1. If less than zero, enter zero.

Part E

Calculate the amount due to DHH, if the floor is applicable, as the lesser of Line C or Line D5.

IF CALCULATION SHOWS MONEY DUE TO THE LOUISIANA DEPARTMENT OF HEALTH DO NOT REMIT PAYMENT WITH THE COST REPORT. PROVIDER WILL BE NOTIFIED OF AMOUNT DUE AFTER DESK REVIEW/AUDIT.

Schedule P

Certification Statement

This page must be completed, signed (original signature – no stamps) and dated by the authorized representative of the facility and the person preparing the cost report. A certification statement that is printed, signed, and scanned is considered an acceptable original signature

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, please email LAICF@mslc.com
and include the name of the template and your name

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part VII. Long Term Care

Subpart 1. Nursing Facilities

NOTE: Subpart 1 Nursing Facilities has been recodifed and moved to LAC 50:II.Chapter 200.

Subpart 3. Intermediate Care Facilities for Persons with Intellectual Disabilities

Chapter 301. General Provisions

§30101. Foreword

A. The ICF/MR standards for payment specify the requirements of federal and state law and regulations governing services provided by intermediate care facilities for the mentally retarded and persons with other developmental disabilities (ICF/MR).

B. The Medicaid Program is administered by the Louisiana Department of Health and Hospitals (DHH) in cooperation with other federal and state agencies.

C. Standards are established to ensure minimum compliance under the law, equity among those served, provision of authorized services, and proper disbursement. If there is a conflict between material in these standards and the federal and state laws or policies governing the program, the state laws or policies governing the program have precedence. These standards provide the ICF/MR with information necessary to fulfill the provider enrollment contract with the agency. It is the ICF/MR facility's responsibility to keep these standards current. The standards are the basis for surveys by federal and state agencies, are part of the enrollment contract, and are necessary for the ICF/MR to remain in compliance with federal and state laws.

D. Monitoring of an ICF/MR's compliance with state and federal regulations is the responsibility of DHH's Bureau of Health Services Financing (BHFS).

E. The Bureau of Health Services Financing (BHSF) Health Standards Section (HSS) is responsible for determining an ICF/MR's compliance with state licensing requirements and compliance with specific Title XIX certification requirements which include physical plant, staffing, dietary, pharmaceuticals, active treatment, and other standards. Minimum licensure requirements for ICF/MRs are covered in the booklet entitled *Licensing Requirements for Residential Care Providers* and Subpart I of the *Code of Federal Regulations*, Chapter 42:483.400-483.480.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:676 (April 1999), repromulgated LR 31:2221 (September 2005).

§30103. Definitions and Acronyms Specific to Mental Retardation and Other Developmental Disabilities

A. Definitions regarding Mental Retardation are adopted from the American Association on Mental Deficiency *Manual on Terminology and Classification in Mental Retardation*, 1977 Edition.

B. Definitions for Developmental Disabilities are taken from the 1983 amended R.S. 28:330-444 based on Public Law 95-602.

C. All clients must meet the criteria for mental retardation and other developmental disabilities in order to qualify for Title XIX reimbursement for ICF/MR services.

AAMR—American Association of Mental Retardation (formerly the AAMDXAmerican Association of Mental Deficiency).

Abuse—the infliction of physical or mental injury to a client or causing a client's deterioration to such an extent that his/her health, moral or emotional well-being is endangered. Examples include, but are not limited to: sexual abuse, exploitation or extortion of funds or other things of value.

Active Treatment—an aggressive and consistent program of specialized and generic training, treatment, health and related services directed toward the acquisition of behaviors necessary for the client to function with as much self determination and independence as possible and the prevention and deceleration of regression or loss of current optimal functional status.

Acuity Factor—an adjustment factor which will modify the direct care portion of the Inventory for Client and Agency Planning (ICAP) rate based on the ICAP level for each resident.

Adaptive Behavior—the effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected for his age and cultural group. Since these exceptions vary for different age groups, deficits in adaptive behavior will vary at different ages.

Administrative and Operating Costs—include:

a. in-house and contractual salaries;

b. benefits;

c. taxes for administration and plant operation maintenance staff;

d. utilities;

e. accounting;

f. insurances;

g. maintenance staff;

h. maintenance supplies;

i. laundry and linen;

j. housekeeping; and

k. other administrative type expenditures.

Agency—see Medicaid Agency.

Ambulatory—an ability to walk about.

ANSI—American National Standards Institute.

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

ART—accredited record technician.

Attending Physician—a physician currently licensed by the Louisiana State Board of Medical Examiners, designated by the client, family, agency, or responsible party as responsible for the direction of overall medical care of the client.

Autism—a condition characterized by disturbance in the rate of appearance and sequencing of developmental milestones:

a. abnormal responses to sensations;

b. delayed or absent speech and language skills while specific thinking capabilities may be present; and

c. abnormal ways of relating to people and things.

BHSF—Bureau of Health Services Financing. See *Health Services Financing*.

Board Certified Social Worker (BCSW)—a person holding a Master of Social Work (MSW) degree who is licensed by the Louisiana State Board of Certified Social Work Examiners.

Capacity for Independent Living—the ability to maintain a full and varied life in one's own home and community.

Capital Costs—include:

a. depreciation;

b. interest expense on capital assets;

c. leasing expenses;

d. property taxes; and

e. other expenses related to capital assets.

Care Related Costs—include in-house and contractual salaries, benefits, taxes, and supplies that help support direct care but do not directly involve caring for the patient and ensuring their well being (e.g., dietary and educational). Care related costs would also include personal items, such as clothing, personal hygiene items (soap, toothpaste, etc), hair grooming, etc.

Cerebral Palsy—a permanently disabling condition resulting from damage to the developing brain, which may occur before, during or after birth and results in loss or impairment of control over voluntary muscles.

Certification—a determination made by the Department of Health and Hospitals (DHH) that an ICF/MR meets the necessary requirements to participate in Louisiana as a provider of Title XIX (Medicaid) Services.

Change in Ownership (CHOW)—any change in the legal entity responsible for the operation of an ICF/MR.

Chief Executive Officer (CEO)—an individual licensed, currently registered, and engaged in the day to day administration/management of an ICF/MR.

Client—an applicant for or recipient of Title XIX (Medicaid) ICF/MR services.

Code of Federal Regulations (CFR)—the regulations published by the federal government. Section 42 includes regulations for ICF/MRs.

Comprehensive Functional Assessment—identifies the client's need for services and provides specific information about the client's ability to function in different environments, specific skills or lack of skills, and how function can be improved, either through training, environmental adaptations, or provision of adaptive, assistive, supportive, orthotic, or prosthetic equipment.

Developmental Disabilities (DD)—severe, chronic disabilities which are attributable to mental retardation, cerebral palsy, autism, epilepsy or any other condition, other than mental illness, found to be closely related to mental retardation. This condition results in an impairment of general intellectual functioning or adaptive behavior similar to that of mental retardation, and requires treatment or services similar to those required for MR/DD are manifested before the person reaches age 22 and are likely to continue indefinitely.

Developmental Period—a period from birth to before a person reaches age 22.

DHH—Department of Health and Hospitals or its designee.

DHHS—the federal Department of Health and Human Services in Washington, D.C.

Direct Care Costs—consist of all costs related to the direct care interaction with the patient. *Direct care costs* include:

a. in-house and contractual salaries;

b. benefits; and

c. taxes for all positions directly related to patient care, including:

i. medical;

ii. nursing;

iii. therapeutic and training;

iv. ancillary in-house services; and

v. recreational.

Dual Diagnosis—clients who carry diagnoses of both mental retardation and mental illness.

Enrollment—process of executing a contract with a licensed and certified ICF/MR provider for participation in the Medical Assistance Program. Enrollment includes the execution of the provider agreement and assignment of the provider number used for payment.

Epilepsy—disorder of the central nervous system which is characterized by repeated seizures which are produced by uncontrolled electrical discharges in the brain.

Facility—an intermediate care facility for the mentally retarded and developmentally disabled.

Fiscal Intermediary—the private fiscal agent with which DHH contracts to operate the Medicaid Management Information System. It processes the Title XIX (Medicaid) claims for services provided under the Medical Assistance Program and issues appropriate payment(s).

General Intellectual Functioning—results obtained by assessment with one or more of the individually administered general intelligence tests developed for that purpose.

HCFA—Health Care Financing Administration.

Health Services Financing, Bureau of (BHSF)—a division of DHH responsible for administering, overseeing, and monitoring the state's Medicaid Program.

HSS—Health Standards Section within BHSF, the section responsible for licensing, certifying and enrolling ICFs/MR.

ICAP—Inventory for Client and Agency Planning. A standardized instrument for assessing adaptive and maladaptive behavior and includes an overall service score. This ICAP service score combines adaptive and maladaptive behavior scores to indicate the overall level of care, supervision or training required.

ICAP Service Level—ranges from 1 to 9 and indicates the service need intensity. The lower the score the greater is the client need.

ICAP Service Score—indicates the level of service intensity required by an individual, considering both adaptive and maladaptive behavior.

NOTE: The relationship between the service level and service score for ICAP support levels is as follows:

ICAP Relationship Graph		
ICAP Service Level	**ICAP Service Score**	**ICAP Support Levels**
		Pervasive+
1	1-19	Pervasive
2	20-29	
3	30-39	Extensive
4	40-49	
5	50-59	Limited
6	60-69	
7	70-79	Intermittent
8	80-89	
9	90+	

Index Factor—this factor will be based on the *Skilled Nursing Home without Capital Market Basket Index* published by Data Resources Incorporated or a comparable index if this index ceases to be published.

Individual Habilitation Plan (IHP)—the written ongoing program of services developed for each client by an interdisciplinary team in order for that client to achieve or maintain his/her potential. The plan contains specific, measurable goals, objectives and provides for data collection.

Individual Plan of Care (IPC)—same as Individual Habilitation Plan.

Individual Program Plan (IPP)—same as Individual Habilitation Plan.

Individual Service Plan (ISP)—same as Individual Habilitation Plan.

Interdisciplinary Team (IDT)—a group of individuals representing the different disciplines in the formulation of a client's individual habilitation plan. That team meets at least annually to develop and review the plans, more frequently if necessary.

Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled (ICF/MR)—same as facility for the mentally retarded or persons with related conditions.

I.Q.—Intelligence Quotient.

Learning—general cognitive competence—the ability to acquire new behaviors, perceptions, and information and to apply previous experiences in new situations.

Legal Status—a designation indicative of an individual's competency to manage their affairs.

Level of Care (LOC)—service needs of the client based upon his/her comprehensive functional status.

Licensed—a determination by the Louisiana Department of Health and Hospitals, Bureau of Health Service Financing, that an ICF/MR meets the state requirements to participate in Louisiana as a provider of ICF/MR services.

Living Unit—a place where a client lives including sleeping, training, dining and activity areas.

LPN—licensed practical nurse.

LSC—life safety code.

LTC—long term care.

Major Life Activities—any one of the following activities or abilities:

a. self-care;

b. understanding and use of language;

c. learning;

d. mobility;

e. self-direction;

f. capacity for independent living.

Measurable Outcomes—a standard or goal by which performance is measured and evaluated.

Mechanical Support—a device used to achieve proper body position or balance.

Medicaid—medical assistance provided according to the State Plan approved under Title XIX of the Social Security Act.

Medicaid Agency—the single state agency responsible for the administration of the Medical Assistance Program (Title XIX). In Louisiana, the Department of Health and Hospitals is the single state agency.

Medicaid Management Information System (MMIS)—the computerized claims processing and information retrieval system which includes all ICF/MR providers eligible for participation in the Medical Assistance Program. This system is an organized method for payment for claims for all Title XIX Services.

Medical Assistance Program (*MAP*)—another name for the Medicaid Program.

Medicare—the federally administered Health Insurance program for the aged, blind and disabled under the Title XVIII of the Social Security Act.

Medicare Part A—the hospital insurance program authorized under Part A of Title XVIII of the Social Security Act.

Medicare Part B—the supplementary medical insurance program authorized under Part B of Title XVIII of the Social Security Act.

Mental Retardation (MR)—significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period.

NOTE: It shall be emphasized that a finding of low I.Q. is never by itself sufficient to make the diagnosis of mental retardation or in evaluating its severity. A low I.Q. shall serve only to help in making a clinical judgment regarding the client's adaptive behavioral capacity. This judgment also includes present functioning, including academic and vocational achievement, motor skills, and social and emotional maturity.

Mobil Nonambulatory—the inability to walk without assistance, but the ability to move from place to place with the use of a device such as a walker, crutches, wheelchair or wheeled platform.

Mobility—motor development and ability to:

a. use fine and gross motor skills;

b. move the extremities at will.

Neglect—the failure to provide proper or necessary medical care, nutrition or other care necessary for a client's well being.

New Facility—an ICF/MR newly opened or recently began participating in the Medical Assistance Program.

Nonambulatory—the inability to walk without assistance.

Nursing Facility or Facility—health care facilities such as a private home, institution, building, residence, or other place which provides maintenance, personal care, or nursing services for persons who are unable to properly care for themselves because of illness, physical infirmity or age. These facilities serve two or more persons who are not related by blood or marriage to the operator and may be operated for profit or nonprofit.

Office for Citizens with Developmental Disabilities (*OCDD*)—the office within DHH responsible for programs serving the MR/DD population.

Operational—admission of at least one client, completion of functional assessments(s) and development of individual program plan(s) for the client(s); and implementation of the program plan(s) in order that the facility actually demonstrate the ability, knowledge, and competence to provide active treatment.

Overall Plan of Care (*OPC*)—see Individual Habilitation Plan.

Pass through Cost Component—includes the provider fee.

Peer Group—the administrative and operating per diem rate and the capital per diem rate are tiered based on peer group size. Peer groups are as follows:

a. 1-8 beds;

b. 9-15 beds;

c. 16-32 beds;

d. 33 or more beds.

Provider—any individual or entity enrolled to furnish Medicaid services under a provider agreement with the Medicaid agency.

Qualified Mental Retardation Professional (QMRP)—a person who has specialized training and at least one year or more of experience in treating and/or working directly with and in direct contact with the mentally retarded clients. To

qualify as a QMRP, a person must meet the requirements of 42 CFR 483.430.

Rate Year—a one-year period corresponding to the state fiscal year from July 1 through June 30.

Rebasing—recalculation of the per diem rate components using the latest available audited or desk reviewed cost reports.

Recipient—an individual who has been determined eligible for Medicaid.

Registered Nurse (RN)—a nurse currently registered and licensed by the Louisiana State Board of Nursing.

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 beneficiary.

Responsible Party—a person authorized by the client, agency or sponsor to act as an official delegate or agent in dealing with the Department of Health and Hospitals and/or the ICF/MR.

Self-Care—daily activities which enable a person to meet basic life needs for food, hygiene, appearance and health.

Self-Direction—management and control over one's social and personal life and the ability to make decisions that affect and protect one's own interests. A substantial functional limitation in self-direction would require a person to need assistance in making independent decisions concerning social and individual activities and/or in handling personal finances and/or in protecting his own self-interest.

Significant Assistance—help needed at least one-half of the time for one activity or a need for some help in more than one-half of all activities normally required for self-care.

Significantly Sub-Average—for purposes of certification for ICF/MR an I.Q. score of below 70 on the Wechsler, Standford-Binet, Cattell, or comparable test will be considered to establish significantly sub-average intellectual functioning.

SNF—Skilled Nursing Facility.

Sponsor—an adult relative, friend, or guardian of the client who has a legitimate interest in or responsibility for the client's welfare. Preferably, this person is designated on the admission forms as "responsible party."

Substantial Functional Limitation—a condition that limits a person from performing normal life activities or makes it unsafe for a person to live alone to such an extent that assistance, supervision, or presence of a second person is required more than half of the time.

Support Levels—describe the levels of support needed by individuals with mental retardation and other developmental disabilities. The five descriptive levels of service intensity using the ICAP assessment are summarized in Subparagraphs a-e below.

a. Intermittent—supports on an as needed basis. Characterized as episodic in nature, the person does not always need the support(s), or short-term supports needed during life-span transition (e.g., job loss or an acute medical crisis). Intermittent supports may be high or low intensity when provided.

b. Limited—supports characterized by consistency over time, time-limited but not of an intermittent nature, may require fewer staff members and less costs than more intense levels of support (e.g., time-limited employment training or transitional supports during the school to adult provided period).

c. Extensive—supports characterized by regular involvement (e.g., daily) in at least some environment (such as work or home) and not time-limited (e.g., long term support and long-term home living support).

d. Pervasive—supports characterized by their constancy, high intensity; provided across environments; potential life-sustaining nature. Pervasive supports typically involve more staff members and intrusiveness than do extensive or time-limited supports.

e. Pervasive Plus—a time-limited specific assignment to supplement required Level of Need services or staff to provide life sustaining complex medical care or to supplement required direct care staff due to dangerous life threatening behavior so serious that it could cause serious physical injury to self or others and requires additional trained support staff to be at “arms length” during waking hours.

Title XIX—see Medicaid.

Training and Habilitation Services—services intended to aid the intellectual, sensorimotor and emotional development of a client as part of overall plans to help the individual function at the greatest physical, intellectual, social and vocational level he/she can presently or potentially achieve.

Understanding and Use of Language—communication involving both verbal and nonverbal behavior enabling the individual both to understand others and to express ideas and information to others.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:676 (April 1999), LR 31:1590 (July 2005), repromulgated LR 31:2222 (September 2005).

Chapter 303. Provider Enrollment

§30301. General Provisions

A. Scope

1. The standards set forth in this and subsequent sections comply with the Title XIX requirements of the amended Social Security Act. That Act sets the standards for the care, treatment, health, safety, welfare and comfort of

Medical Assistance clients in facilities providing ICF/MR services.

2. These standards apply to ICF/MRs certified and enrolled by the Louisiana Department of Health and Hospitals (DHH) for vendor participation.

3. These standards supplement current licensing requirements applicable to ICF/MRs. Any infraction of these standards may be considered a violation of the provider agreement between DHH and the ICF/MR.

4. In the event any of these standards are not maintained, DHH will determine whether facility certification will continue with deficiencies as is allowed under Title XIX regulations or whether termination of the provider agreement is warranted. Although vendor payment will not be suspended during the determination period, deficiencies which may affect the health, safety, rights and welfare of Medical Assistance clients must be corrected expeditiously in order for the ICF/MR to continue to participate.

5. If a certified ICF/MR is found to have deficiencies which immediately jeopardize the health, safety, rights and welfare of its Medical Assistance clients, DHH may initiate proceedings to terminate the ICF/MR's certification. In the event of less serious deficiencies, DHH may impose interim sanctions (see Chapter 323, Sanctions).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 42 CFR 442- 483.400 and 435.1008.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Undersecretary, Bureau of Health Services Financing, LR 25:682 (April 1999), repromulgated LR 31:2225 (September 2005).

§30303. General Admission and Funding

A. Capacity. The ICF/MR will admit only the number of individuals that does not exceed its rated capacity as determined by the BHSF's HSS and its capacity to provide adequate programming.

B. Admission Requirements. Except on a short term emergency basis, an ICF/MR may not admit individuals as clients unless their needs can be met and an interdisciplinary professional team has determined that admission is the best available plan for them. The team must do the following:

1. conduct a comprehensive evaluation of each individual that covers physical, emotional, social and cognitive factors; and

2. perform the following tasks prior to admission:

a. define the individual's need for service without regard to the availability of those services; and

b. review all appropriate programs of care, treatment, and training and record the findings;

3. ensure that the ICF/MR takes the following action if admission is not the best plan but the individual must nevertheless be admitted:

a. clearly acknowledges that admission is inappropriate; and

b. initiates plans to actively explore alternatives.

C. Prohibitions on Federal Financial Participation

1. Federal funds in the Title XIX ICF/MR program are not available for clients whose individual treatment plans are totally or predominately vocational and/or educational. ICF/MR services are designed essentially for those individuals diagnosed as developmentally disabled; having developmental lags which are considered amendable to treatment in a 24-hour managed care environment where they will achieve maximum growth. Services to treat educational and vocational deficits are available at the community level while the client lives in his home or in another community level placement and are not considered amendable to treatment in a 24-hour managed care environment.

2. Admissions through the Court System

a. Court ordered admissions do not guarantee Medicaid vendor payment to a facility. A court can order that a client be placed in a particular facility but cannot mandate that the services be paid for by the Medicaid program.

b. Incarcerated individuals are not eligible for Medicaid. The only instance in which such an individual may qualify is if he/she is paroled or released on medical furlough.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 42 CFR 483.440.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Undersecretary, Bureau of Health Services Financing, LR 25:682 (April 1999), repromulgated LR 31:2225 (September 2005).

§30305. Program Enrollment

A. An ICF/MR may enroll for participation in the Medical Assistance Program (Title XIX) when all the following criteria have been met:

1. the ICF/MR has received Facility Need Review approval from DHH;

2. the ICF/MR has received approval from DHH/OCDD;

3. the ICF/MR has completed an enrollment application for participation in the Medical Assistance Program;

4. the ICF/MR has been surveyed for compliance with federal and state standards, approved for occupancy by the Office of Public Health (OPH) and the Office of the State Fire Marshal, and has been determined eligible for certification on the basis of meeting these standards; and

5. the ICF/MR has been licensed and certified by DHH.

B. Procedures for Certification of New ICF/MRs. The following procedures must be taken in order to be certified as a new ICF/MR.

1. The ICF/MR shall apply for a license and certification.

2. DHH shall conduct or arrange for surveys to determine compliance with Title XIX, Title VI (Civil Rights), Life Safety, and Sanitation Standards.

3. Facilities must be operational a minimum of two weeks (14 calendar days) prior to the initial certification survey. Facilities are not eligible to receive payment prior to the certification date.

a. *Operational* is defined as admission of at least one client, completion of functional assessment and development of individual program plan for each client; and implementation of the program plan(s) in order for the facility to actually demonstrate the ability, knowledge, and competence to provide active treatment.

b. Fire and health approvals must be obtained from the proper agencies prior to a client's admission to the facility.

c. The facility must comply with all standards of the State of Louisiana licensing requirements for residential care providers.

d. A certification survey will be conducted to verify that the facility meets all of these requirements.

4. A new ICF/MR shall be certified only if it is in compliance with all conditions of participation found in 42 CFR 442 and 42 CFR 483.400 et seq.

5. The effective date of certification shall be no sooner than the exit date of the certification survey.

C. Certification Periods

1. DHH may certify an ICF/MR which fully meets applicable requirements for a maximum of 12 months.

2. Prior to the agreement expiration date, the provider agreement may be extended for up to two months after the agreement expiration date if the following conditions are met:

a. the extension will not jeopardize the client's health, safety, rights and welfare; and

b. the extension is needed to prevent irreparable harm to the ICF/MR or hardship to its clients; or

c. the extension is needed because it is impracticable to determine whether the ICF/MR meets certification standards before the expiration date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 42 CFR 483.440.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Undersecretary, Bureau of Health Services Financing, LR 25:682 (April 1999), repromulgated LR 31:2226 (September 2005).

§30307. Ownership

A. Disclosure. All participating Title XIX ICF/MRs are required to supply the DHH Health Standards Section with a completed HCFA Form 1513 (Disclosure of Ownership) which requires information as to the identity of the following individuals:

1. each person having a direct or indirect ownership interest in the ICF/MR of 5 percent or more;

2. each person owning (in whole or in part) an interest of 5 percent or more in any property, assets, mortgage, deed of trust, note or other obligation secured by the ICF/MR;

3. each officer and director when an ICF/MR is organized as a corporation;

4. each partner when an ICF/MR is organized as a partnership;

5. within 35 days from the date of request, each provider shall submit the complete information specified by the BHSF/HSS regarding the following:

a. the ownership of any subcontractor with whom this ICF/MR has had more than $25,000 in business transactions during the previous 12 months; and

b. information as to any significant business transactions between the ICF/MR and the subcontractor or wholly owned suppliers during the previous five years.

B. The authorized representative must sign the provider agreement.

1. If the provider is a nonincorporated entity and the owner does not sign the provider agreement, a copy of power of attorney shall be submitted to the DHH/HSS showing that the authorized representative is allowed to sign on the owner's behalf.

2. If one partner signs on behalf of another partner in a partnership, a copy of power of attorney shall be submitted to the DHH/HSS showing that the authorized representative is allowed to sign on the owner's behalf.

3. If the provider is a corporation, the board of directors shall furnish a resolution designating the representative authorized to sign a contract for the provision of services under DHH's state Medical Assistance Program.

C. Change in Ownership (CHOW)

1. A Change in Ownership (CHOW) is any change in the legal entity responsible for the operation of the ICF/MR.

2. As a temporary measure during a change of ownership, the BHSF/HSS shall automatically assign the provider agreement and certification, respectively to the new owner. The new owner shall comply with all participation prerequisites simultaneously with the ownership transfer. Failure to promptly complete with these prerequisites may result in the interruption of vendor payment. The new owner shall be required to complete a new provider agreement and

enrollment forms referred to in Continued Participation. Such an assignment is subject to all applicable statutes, regulations, terms and conditions under which it was originally issued including, but not limited to, the following:

a. any existing correction action plan;

b. any expiration date;

c. compliance with applicable health and safety standards;

d. compliance with the ownership and financial interest disclosure requirements;

e. compliance with Civil Rights requirements;

f. compliance with any applicable rules for Facility Need Review;

g. acceptance of the per diem rates established by DHH/BHSF's Institutional Reimbursement Section; and

h. compliance with any additional requirements imposed by DHH/BHSF/HSS.

3. For an ICF/MR to remain eligible for continued participation after a change of ownership, the ICF/MR shall meet all the following criteria:

a. state licensing requirements;

b. all Title XIX certification requirements;

c. completion of a signed provider agreement with the department;

d. compliance with Title VI of the Civil Rights Act; and

e. enrollment in the Medical Management Information system (MMIS) as a provider of services.

4. A facility may involuntarily or voluntarily lose its participation status in the Medicaid Program. When a facility loses its participation status in the Medicaid Program, a minimum of 10 percent of the final vendor payment to the facility is withheld pending the fulfillment of the following requirements:

a. submission of a limited scope audit of the client's personal funds accounts with findings and recommendations by a qualified accountant of the facility's choice to the department's Institutional Reimbursement Section:

i. the facility has 60 days to submit the audit findings to Institutional Reimbursement once it has been notified that a limited scope audit is required;

ii. failure of the facility to comply with the audit requirement is considered a Class E violation and will result in fines as outlined in Chapter 323, Sanctions;

b. the facility's compliance with the recommendations of the limit scope audit;

c. submittal of an acceptable final cost report by the facility to Institutional Reimbursement;

d. once these requirements are met, the portion of the payment withheld shall be released by the BHSF's Program Operations Section.

5. Upon notification of completion of the ownership transfer and the new owner's licensing, DHH/HSS will notify the fiscal intermediary regarding the effective dates of payment and to whom payment is to be made.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 42 CFR 420.205, 440.14, 442.15, 455.100, 455.101, 455.102, and 455.103.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Undersecretary, Bureau of Health Services Financing, LR 25:682 (April 1999), repromulgated LR 31:2226 (September 2005).

§30309. Provider Agreement

A. In order to participate as a provider of ICF/MR services under Title XIX, an ICF/MR must enter into a provider agreement with DHH. The provider agreement is the basis for payments by the Medical Assistance Program. The execution of a provider agreement and the assignment of the provider's Medicaid vendor number is contingent upon the following criteria.

1. Facility Need Review Approval Required. Before the ICF/MR can enroll and participate in Title XIX, the Facility Need Review Program must have approved the need for the ICF/MR's enrollment and participation in Title XIX. The Facility Need Review process is governed by Department of Health and Hospitals regulations promulgated under authority of Louisiana R.S. 40:2116.

a. The approval shall designate the appropriate name of the legal entity operating the ICF/MR.

b. If the approval is not issued in the appropriate name of the legal entity operating the ICF/MR, evidence shall be provided to verify that the legal entity that obtained the original Facility Need Review approval is the same legal entity operating the ICF/MR.

2. ICF/MR's Medicaid Enrollment Application. The ICF/MR shall request a Title XIX Medicaid enrollment packet from the Medical Assistance Program Provider Enrollment Section. The information listed below shall be returned to that office as soon as it is completed:

a. two copies of the Provider Agreement Form with the signature of the person legally designated to enter into the contract with DHH;

b. one copy of the Provider Enrollment Form (PE 50) completed in accordance with accompanying instructions and signed by the administrator or authorized representative;

c. one copy of the Title XIX Utilization Review Plan Agreement Form showing that the ICF/MR accepts DHH's Utilization Review Plan;

d. copies of information and/or legal documents as outlined in §30307 (Ownership).

3. The Effective Date of the Provider Agreement. The ICF/MR must be licensed and certified by the BHSF/HSS in accordance with provisions in 42 CFR 442.100-115 and provisions determined by DHH. The effective date of the provider agreement shall be determined as follows.

a. If all federal requirements (health and safety standards) are met on the day of the BHSF/HSS survey, then the effective date of the provider agreement is the date the on-site survey is completed or the day following the expiration of a current agreement.

b. If all requirements are specified in Subparagraph a above are not met on the day of the BHSF/HSS survey, the effective date of the provider agreement is the earliest of the following dates:

i. the date on which the provider meets all requirements; or

ii. the date on which the provider submits a corrective action plan acceptable to the BHSF/HSS; or

iii. the date on which the provider submits a waiver request approved by the BHSF/HSS; or

iv. the date on which both Clause ii and Clause iii above are submitted and approved.

4. ICF/MR's "Per Diem" Rate. After the ICF/MR facility has been licensed and certified, a per diem rate will be issued by the department.

5. Provider Agreement Responsibilities. The responsibilities of the various parties are spelled out in the Provider Agreement Form. Any changes will be promulgated in accordance with the Administrative Procedure Act.

6. Provider Agreement Time Periods. The provider agreement shall meet the following criteria in regard to time periods.

a. It shall not exceed 12 months.

b. It shall coincide with the certification period set by the BHSF/HSS.

c. After a provider agreement expires, payment may be made to an ICF/MR for up to 30 days.

d. The provider agreement may be extended for up to two months after the expiration date under the following conditions:

i. it is determined that the extension will not jeopardize the client's health, safety, rights and welfare; and

ii. it is determined that the extension is needed to prevent irreparable harm to the ICF/MR or hardship to its clients; or

iii. it is determined that the extension is needed because it is impracticable to determine whether the ICF/MR meets certification standards before the expiration date.

7. Tuberculosis (TB) Testing as Required by the OPH. All residential care facilities licensed by DHH shall comply with the requirements found in LAC 51:II.Chapter 5 regarding screening for communicable disease of employees, residents, and volunteers whose work involves direct contact with clients. For questions regarding TB testing, contact the local office of Public Health.

8. Criminal History Checks. Effective July 15, 1996, the Office of State Police will perform criminal history checks on nonlicensed personnel of health care facilities in accordance with R.S. 40:1300.51-R.S. 40:1300.56.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and 42 CFR 431.107, 442.10, 442.12, 442.13, 442.15, 442.16, 442.100 and 442.101.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:679 (April 1999), repromulgated LR 31:2227 (September 2005).

Chapter 305. Admission Review

§30501. Admission Process

A. ICF/MRs will be subject to a review of each client's need for ICF/MR services.

B. Interdisciplinary Team (ID Team). Before admission to an ICF/MR, or before authorization for payment, an interdisciplinary team of health professionals will make a comprehensive medical, social and psychological evaluation of each client's need for care in the ICF/MR.

1. Other professionals as appropriate will be included on the team, and at least one member will meet the definition of Qualified Mental Retardation Professional (QMRP) as stated in these standards.

2. Appropriate participation of nursing services on this team should be represented by a Louisiana licensed nurse.

C. Exploration of Alternative Services. If the comprehensive evaluations recommend ICF/MR services for a client whose needs could be met by alternative services that are currently unavailable, the ICF/MR will enter this fact in the client's record and begin to look for alternative services.

D. ICF/MR Submission of Data

1. Evaluative data for medical certification for ICF/MR level of care will be submitted to the appropriate regional Health Standards Office on each client. This will include the following information:

a. initial application;

b. applications for clients transferring from one ICF/MR to another;

c. applications for clients transferring from an acute care hospital to an ICF/MR;

d. applications for clients who are patients in a mental health facility; and

e. applications for clients already in an ICF/MR program.

2. Time Frames for Submission of Data. A complete packet of admission information must be received by BHSF/HSS within 20 working days following the completion of the ISP for newly admitted clients.

a. Notice within the 20-day time frame will also be required for readmissions and transfers.

b. If an incomplete packet is received, denial of certification will be issued with the reasons(s) for denial.

c. If additional information is subsequently received within the initial 20-working-day time frame, and the client meets all requirements, the effective date of certification is the date of admission.

d. If the additional information is received after the initial 20-working-day time frame and the client meets all requirements, the effective date of certification is no earlier than the date a completed packet is received by HSS.

3. Data may be submitted before admission of the client if all other conditions for the admission are met.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 456.350-456.438.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:697 (April 1999), repromulgated LR 31:2228 (September 2005).

§30503. Certification Requirements

A. The following documentation and procedures are required to obtain medical certification for ICF/MR Medicaid vendor payment. The documentation should be submitted to the appropriate HSS regional office.

1. Social evaluation:

a. must not be completed more than 90 days prior to admission and no later than date of admission; and

b. must address the following:

i. family, educational and social history including any previous placements;

ii. treatment history that discusses past and current interventions, treatment effectiveness, and encountered negative side effects;

iii. current living arrangements;

iv. family involvement, if any;

v. availability and utilization of community, educational, and other sources of support;

vi. habilitation needs;

vii. family and/or client expectations for services;

viii. prognosis for independent living; and

ix. social needs and recommendation for ICF/MR placement.

2. Psychological evaluation:

a. must not be completed more than 90 days prior to admission and no later than the date of admission; and

b. must include the following components:

i. comprehensive measurement of intellectual functioning;

ii. a developmental and psychological history and assessment of current psychological functioning;

iii. measurement of adaptive behavior using multiple informants when possible;

iv. statements regarding the reliability and validity of informant data including discussion of potential informant bias;

v. detailed description of adaptive behavior strengths and functional impairments in self-care, language, learning, mobility, self-direction, and capacity for independent living;

vi. discussion of whether impairments are due to a lack of skills or noncompliance and whether reasonable learning opportunities for skill acquisition have been provided; and

vii. recommendations for least restrictive treatment alternative, habilitation and custodial needs and needs for supervision and monitoring to ensure safety.

3. A psychiatric evaluation must be completed if the client has a primary or secondary diagnosis of mental illness, is receiving psychotropic medication, has been hospitalized in the past three years for psychiatric problems, or if significant psychiatric symptoms were noted in the psychological evaluation or social assessment. The psychiatric evaluation:

a. shall not be completed more than 90 days prior to admission and no later than the date of admission;

b. should include a history of present illness, mental status exam, diagnostic impression, assessment of strengths and weaknesses, recommendations for therapeutic interventions, and prognosis; and

c. may be requested at the discretion of HSS to determine the appropriateness of placement if admission material indicates the possible need for psychiatric intervention due to behavior problems.

4. Physical, occupational, or speech therapy evaluation(s) may be requested when the client receives services or is in need of services in these areas.

5. An individual service plan (ISP) developed by the interdisciplinary team, completed within 30 days of admission that describes and documents the following:

a. habilitation needs;

b. specific objectives that are based on assessment data;

c. specific services, accommodations, and/or equipment needed to augment other sources of support to facilitate placement in the ICF/MR; and

d. participation by the client, the parent(s) if the client is a minor, or the client's legal guardian unless participation is not possible or inappropriate.

NOTE: Document the reason(s) for any nonparticipation by the client, the client's parent(s), or the client's legal guardian.

6. Form 90-L (Request for Level of Care Determination) must be submitted on each admission or readmission. This form must:

a. not be completed more than 30 days before admission and not later than the date of admission;

b. be completed fully and include prior living arrangements and previous institutional care;

c. be signed and dated by a physician licensed to practice in Louisiana. Certification will not be effective any earlier than the date the Form 90-L is signed and dated by the physician;

d. indicate the ICF/MR level of care; and

e. include a diagnosis of mental retardation/developmental disability or related condition as well as any other medical condition.

7. Form 148 (Notification of Admission or Change):

a. must be submitted for each new admission to the ICF/MR;

b. must be submitted when there is a change in a client's status: death, discharge, transfer, readmission from a hospital;

c. for clients' whose application for Medicaid is later than date of admission, the date of application must be indicated on the form.

8. Transfer of a Client

a. Transfer of a Client Within an Organization

i. Form 148 must be submitted by both the discharging facility and the admitting facility. It should indicate the date the client was discharged from the transferring facility plus the name of the receiving facility and the date admitted.

ii. An updated individual service plan must be submitted from the discharging facility to the receiving facility. The previous plan can be used but must show any necessary revisions that the receiving facility ID team feels appropriate and/or necessary.

iii. The receiving facility must submit minutes of an ID team meeting addressing the reason(s) for the transfer, the family and client's response to the move, and the signatures of the persons attending the meeting.

b. Transfer of a Client Not Within the Same Organization. Certification requirements involving the transfer of a client from one ICF/MR facility to another not within the same organization or network will be the same as for a new admission.

i. The discharging facility will notify HSS of the discharge by submitting Form 148 giving the date of discharge and destination.

ii. The receiving facility must follow all steps for a new admission.

9. Readmission of a Client Following Hospitalization

a. Form 148 must be submitted showing the date Medicaid billing was discontinued and the date of readmission to the facility.

b. Documentation must be submitted that specifies the client's diagnosis, medication regime, and includes the physician's signature and date. The documentation can be:

i. Form 90-L;

ii. hospital transfer form;

iii. hospital discharge summary; or

iv. physician's orders.

c. An updated ISP must be submitted showing changes, if any, as a result of the hospitalization.

10. Readmission of a Client Following Exhausted Home Leave Days

a. Form 148 must be submitted showing the date billing was discontinued and the date of readmission.

b. An updated ISP must be submitted showing changes, if any, as a result of the extended home leave.

11. Transfer of a Client From an ICF/MR Facility to a Nursing Facility. When a client's medical condition has deteriorated to the extent that they cannot participate in or benefit from active treatment and require 24-hour nursing care, the ICF/MR may request prior approval from HSS to transfer the client to a nursing facility by submitting the following information:

a. Form 148 showing that transfer to a nursing facility is being requested;

b. Form 90-L completed within 30 days prior to request for transfer indicating that nursing facility level of care is needed;

c. Level 1 PASARR completed within 30 days prior to request for transfer;

d. ID team meeting minutes addressing the reason for the transfer, the family and client's response to the move, and the signatures of the persons attending the meeting; and

e. any other medical information that will support the need for nursing facility placement.

12. Inventory for Client and Agency Planning (ICAP) service score;

13. Level of Needs and Services (LONS) summary sheet.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:698 (April 1999), LR 30:1702 (August 2004), repromulgated LR 31:2229 (September 2005).

Chapter 307. Records

Subchapter A. Client Records

§30701. General Requirements

A. Written Policies and Procedures. An ICF/MR facility shall have written policies and procedures governing access to, publication of, and dissemination of information from client records.

B. Protection of Records. Client records are the property of the ICF/MR residents and as such shall be protected from loss, damage, tampering, or use by unauthorized individuals. Records may be removed from the ICF/MR's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute.

C. Confidentiality. An ICF/MR facility shall ensure confidential treatment of client records, including information contained in automatic data banks.

1. The client's written consent, if the client is determined competent, shall be required for the release of information to any persons not otherwise authorized under law to receive it. If the client is not documented as competent, a member of the family, responsible party or advocate shall be required to sign.

NOTE: “Blanket” signed authorizations for release of information from client records are time limited.

2. A record of all disclosures from client's records shall be kept.

3. All staff shall be trained in the policies regarding confidentiality during orientation to the ICF/MR and in subsequent on-the-job and in-service training.

4. Any information concerning a client or family considered too confidential for general knowledge by the ICF/MR staff shall be kept in a separate file by the chief executive officer, his designee, or social worker. A notation regarding the whereabouts of this information shall be made in the client's record.

D. Availability of Records. The ICF/MR shall make necessary records available to appropriate state and federal personnel upon request.

E. Records Service System

1. The ICF/MR shall maintain an organized central record service for collecting and releasing client information. Copies of appropriate information shall be available in the client living units.

2. A written policy shall be maintained regarding a "charge out system" by which a client's record may be located when it is out of file.

3. The ICF/MR shall maintain a master alphabetical index of all clients.

4. All records shall be maintained in such a fashion as to protect the legal rights of clients, the ICF/MR, and ICF/MR staff.

F. General Contents of Records. A written record shall be maintained for each client.

1. Records shall be adequate for planning and for continuously evaluating each client's habilitation plan and documenting each client's response to and progress in the habilitation plan.

2. Records shall contain sufficient information to allow staff members to execute, monitor and evaluate each client's habilitation program.

G. Specifics Regarding Entries into Client Records. The following procedures shall be adhered to when making entries into a client's record.

1. All entries shall be legible, signed, and dated by the person making the entry.

2. All corrections shall be initialed and completed in such a manner that the original entry remains legible.

3. Entries shall be dated only on the date when they are made.

4. The ICF/MR shall maintain a roster of signatures, initials and identification of individuals making entries in each record.

H. Components of Client Records. Components of client records shall include, but shall not be limited to, the following:

1. admission records;

2. personal property records;

3. financial records;

4. medical records.

a. This includes records of all treatments, drugs, and services for which vendor payments have been made, or which are to be made, under the Medical Assistance Program.

b. This includes the authority for and the date of administration of such treatment, drugs, or services.

c. The ICF/MR shall provide sufficient documentation to enable DHH to verify that each charge is due and proper prior to payment.

5. All other records which DHH finds necessary to determine a ICF/MR's compliance with any federal or state law, rule or regulation promulgated by the DHH.

I. Retention of Records. The ICF/MR shall retain records for whichever of the following time frames is longer:

1. until records are audited and all audit questions are answered;

2. in the case of minors, three years after they become 18 years of age; or

3. three years after the date of discharge, transfer, or death of the client.

J. Interdicted Client. If the ICF/MR client has been interdicted, a copy of the legal documents shall be contained in the client's records.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 42 CFR 433 and 42 CFR 483.400.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:684 (April 1999), repromulgated LR 31:2230 (September 2005).

§30703. Admission Records

A. At the time of admission to the ICF/MR, information shall be entered into the client's record which shall identify and give a history of the client. This identifying information shall at least include the following:

1. a recent photograph;

2. full name;

3. sex;

4. date of birth;

5. ethnic group;

6. birthplace;

7. height;

8. weight;

9. color of hair and eyes;

10. identifying marks;

11. home address, including street address, city, parish and state;

12. Social Security Number;

13. medical assistance identification number;

14. Medicare claim number, if applicable;

15. citizenship;

16. marital status;

17. religious preference;

18. language spoken or understood;

19. dates of service in the United States Armed Forces, if applicable;

20. legal competency status if other than competent;

21. sources of support: social security, veterans' benefits, etc.;

22. father's name, birthplace, Social Security Number, current address, and current phone number;

23. mother's maiden name, birthplace, Social Security Number, current address, and current phone number;

24. name, address, and phone number of next of kin, legal guardian, or other responsible party;

25. date of admission;

26. name, address and telephone number of referral agency or hospital;

27. reason for admission;

28. admitting diagnosis;

29. current diagnosis, including primary and secondary DSM III diagnosis, if applicable;

30. medical information, such as allergies and general health conditions;

31. current legal status;

32. personal attending physician and alternate, if applicable;

33. choice of other service providers;

34. name of funeral home, if appropriate; and

35. any other useful identifying information. Refer to *Admission Review* for procedures.

B. First Month After Admission. Within 30 calendar days after a client's admission, the ICF/MR shall complete and update the following:

1. review and update the pre-admission evaluation;

2. develop a prognosis for programming and placement;

3. ensure that an interdisciplinary team completes a comprehensive evaluation and designs an individual habilitation plan (IHP) for the client which includes a 24-hour schedule.

C. Entries into Client Records During Stay at the ICF/MR. The following information shall be added to each client's record during his/her stay at the ICF/MR:

1. reports of accidents; seizures, illnesses, and treatments for these conditions;

2. records of immunizations;

3. records of all periods where restraints were used, with authorization and justification for each, and records of monitoring in accordance with these standards;

4. reports of at least an annual review and evaluation of the program, developmental progress, and status of each client, as required in these standards;

5. behavior incidents and plans to manage inappropriate behavior;

6. records of visits and contacts with family and other persons;

7. records of attendance, absences, and visits away from the ICF/MR;

8. correspondence pertaining to the client;

9. periodic updates of the admission information (such updating shall be performed in accordance with the written policy of the ICF/MR but at least annually); and

10. appropriate authorizations and consents.

D. Entries at Discharge. At the time of a client's discharge, the QMRP or other professional staff, as appropriate, shall enter a discharge summary into the client's record. This summary shall address the findings, events, and progress of the client while at the ICF/MR and a diagnosis, prognosis, and recommendations for future programming.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Undersecretary, Bureau of Health Services Financing, LR 25:685 (April 1999), repromulgated LR 31:2231 (September 2005).

§30705. Medical Records

A. General Requirements. The ICF/MR shall maintain medical records which include clinical, medical, and psychosocial information on each client.

B. Components of Medical Records. Each client's record shall consist of a current active medical section and the ICF/MR's medical files or folders.

1. Active Medical Section. The active medical section shall contain the following information:

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

b. physician certification of the clients' need for admission to the ICF/MR;

c. physician recertification that the client continues to require the services of the ICF/MR;

d. nurses quarterly physical assessment. See §31101, Client Health and Habilitative Services;

e. quarterly, the pharmacy consultant must review the drug regimen of each client;

f. certification that each IHP has been periodically reviewed and revised.

2. Medical Files. As the active medical section becomes bulky, the outdated information shall be removed and filed in the ICF/MR's medical files.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Undersecretary, Bureau of Health Services Financing, LR 25:685 (April 1999), repromulgated LR 31:2232 (September 2005).

§30707. Personal Property Records

A. The ICF/MR shall permit clients to maintain and use their personal property. The number of personal possessions may be limited only for health and safety reasons. When such limitations are imposed, documentation is required in the client's records.

1. Within 24 hours after admission, the ICF/MR shall prepare a written inventory of the personal property a client brings to the ICF/MR.

2. The facility authorized representative shall sign and retain the written inventory and shall give a copy to the client, family or responsible party.

3. The ICF/MR shall revise the written inventory to show if acquired property is lost, destroyed, damaged, replaced or supplemented.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 42 CFR 483.420.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:686 (April 1999), repromulgated LR 31:2232 (September 2005).

§30709. Financial Records

A. General Requirements. Clients have the right to maintain their personal funds or to designate someone to assume this responsibility for them. Clients' income may be from social security, supplemental security income (SSI), optional state supplementation, other sources (VA or insurance benefits, etc.) or earnings of the client. A portion of the clients' income is used to pay the clients' share (liability) of the monthly charges for the ICF/MR. The ICF/MR shall:

1. have written policies and procedures for protecting clients' funds and for counseling clients concerning the use of their funds;

2. develop written procedures for the recording and accounting of client's personal funds;

NOTE: ICF/MRs shall ensure the soundness and accuracy of the client fund account system.

3. train clients to manage as many of their financial affairs as they are capable. Documentation must support that training was provided and the results of that training;

4. maintain current records that include the name of the person (client or person designated) handling each client's personal funds;

5. be responsible for the disbursements, deposits, soundness, and accuracy of the clients' personal funds account when arrangements are made with a federal or state insured banking institution to provide banking services for the clients;

NOTE: All bank charges, including charges for ordering checks, shall be paid by the ICF/MR and not charged to the clients' personal funds account(s).

6. maintain current, written individual ledger sheet records of all financial transactions involving client's personal funds which the facility is holding and safeguarding;

NOTE: ICF/MRs shall keep these records in accordance with requirements of law for a trustee in a fiduciary relationship.

7. make personal fund account records available upon request to the client, family, responsible party, and DHH.

B. Components Necessary for a Client Fund Account System. The ICF/MR shall:

1. maintain current, written individual records of all financial transactions involving clients' personal funds which the ICF/MR is holding, safeguarding, and accounting;

2. keep these records in accordance with requirements of law for a trustee in a fiduciary relationship which exists for these financial transactions;

3. develop the following procedures to ensure a sound and workable fund accounting system.

a. Individual Client Participation File. Client=s ledger sheet shall consist of the following criteria.

i. A file shall exist for each participating client. Each file or record shall contain all transactions pertinent to the account, including the following information:

(a). name of the client and date of admission;

(b). deposits

(i). date;

(ii). source; and

(iii). amount;

(c). withdrawals:

(i). date;

(ii). check/petty cash voucher number;

(iii). payee (if check is issued);

(iv). purpose of withdrawal; and

(v). amount;

(d). fund balance after each transaction.

NOTE: Checks shall not be payable to "cash" or employees of the facility.

ii. Maintain receipts or invoices for disbursements that shall include the following information:

(a). the date;

(b). the amount;

(c). the description of items purchased; and

(d). the signature of the client, family, or responsible party to support receipt of items.

iii. Supporting documentation shall be maintained for each withdrawal as follows:

(a). cash register receipt with canceled check or petty cash voucher signed by the client; or

(b). invoice with canceled check or petty cash voucher signed by the client; or

(c). petty cash voucher signed by the client; or

(d). canceled check.

NOTE: Canceled checks written to family members or responsible parties are sufficient receipts for disbursements if coupled with information regarding the purpose of expenditures.

iv. Supporting documentation shall be maintained for each deposit as follows:

(a). receipts for all cash received on behalf of the residents; and

(b). copies of all checks received on behalf of the residents.

v. All monies, either spent on behalf of the client or withdrawn by the client, family, or responsible party, shall be supported on the individual ledger sheet by a receipt, invoice, canceled check, or signed voucher on file.

NOTE: It is highly recommended that the functions for actual disbursement of cash and reconciling of the cash disbursement record be performed by separate individuals.

vi. The file shall be available to the client, family, or other responsible party upon request during the normal administrative work day.

b. Client's Personal Funds Bank Account(s). ICF/MRs may deposit clients' money in individual or collective bank account(s). The individual or collective account(s) shall:

i. be separate and distinct from all ICF/MR facility accounts;

ii. consist solely of clients' money and shall not be commingled with the ICF/MR facility account(s);

iii. personal fund record shall be:

(a). maintained at the facility; and

(b). available daily upon request during banking hours.

c. Reconciliations of Client's Personal Funds Account(s). There shall be a written reconciliation, at least

monthly, by someone other than the custodian of the client's personal funds account(s). AAssets≅ (cash in bank, both checking and savings) must equal Aliabilities≅ [ledger sheet balance(s)]. Collective bank accounts shall be reconciled to the total of client's ledger sheet balances. The reconciliation shall be reviewed and approved by someone other than the preparer or custodian of the client's personal funds account.

d. Unallowable Charges to Client's Personal Funds Account(s). It is the intent of the State of Louisiana that ICF/MRs provide total maintenance for recipients. The client's personal funds should be set aside for individual wants or to spend as the client sees fit. In the event that a client desires to purchase a certain brand, he/she has the right to use his/her personal funds in this manner; however, the client must be made aware of what the facility is providing prior to making his/her decision. Written documentation must be maintained to support that the client was made aware of products or services the facility is obligated to provide. Listed below (but not limited to) are items that shall not be charged to a client's personal funds account(s), the client's family or responsible party(s):

i. clothing. If a client does not have adequate seasonal clothing (including shoes, etc.), it is the responsibility of the facility to provide the clothing;

ii. personal hygiene items;

iii. haircuts;

iv. dentures/braces, etc.;

v. eyeglasses;

vi. hearing and other communication aids;

vii. support braces;

viii. any other devices identified by the interdisciplinary team;

ix. wheelchairs;

x. repair and maintenance of items listed in Clauses iv-ix;

xi. damage to facility property or the client's possessions. The client may not be charged for damage to facility property or the property of others caused by that individual's destructive behavior. ICF/MRs have a general responsibility to maintain the environment as a cost of doing business. Property of clients damaged or stolen by others must be replaced by the facility;

xii. transportation;

xiii. prescription or over-the-counter drugs;

xiv. recreational costs included in the IHP;

xv. medical expenses of any nature;

xvi. tips, gifts, expenses for staff;

xvii. supplies or items to meet goals of IHP.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 42 CFR 483.420(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:686 (April 1999), repromulgated LR 31:2232 (September 2005).

§30711. Cash on Hand

A. ICF/MRs shall have a minimum of cash on hand to meet client's spending needs. Cash on hand shall be maintained on the imprest petty cash system which includes pre-numbered petty cash vouchers. Petty cash shall be maintained at the facility and shall be available to the clients 24 hours a day, seven days a week.

B. The facility shall provide the funds to implement the petty cash system and replenish it, as necessary, from the clients' personal funds based on signed vouchers. Vouchers may be signed by clients, families, or responsible parties. When residents cannot sign their name, vouchers shall be signed by two witnesses. Checks issued to replenish the fund should be made payable to a Custodian of Petty Cash. When funds are withdrawn from the clients' savings account to cover signed vouchers, a receipt signed by the custodian of petty cash shall be maintained in lieu of a canceled check.

C. There shall be a written reconciliation, at least weekly, by someone other than the custodian of the petty cash fund. The reconciliation shall be reviewed and approved by someone other than the preparer or custodian of the petty cash fund.

NOTE: The facility is responsible for shortages.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Undersecretary, Bureau of Health Services Financing, LR 25:687 (April 1999), repromulgated LR 31:2234 (September 2005).

§30713. Access to Funds

A. Clients shall have access to their funds during hours compatible to banking institutions in the community where they live. Large ICF/MRs shall post the times when clients shall have access to their funds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:688 (April 1999), repromulgated LR 31:2234 (September 2005).

§30715. Closing a Discharged Client's Fund Account

A. When a client is discharged, the ICF/MR shall refund the balance of a client's personal account and that portion of any advance payment not applied directly to the ICF/MR fee. The amount shall be refunded to the client, family or other responsible party within 30 days following the date of discharge. Date, check number, and "to close account"

should be noted on the ledger sheet. When the facility is the payee for a social security check or other third party payments, the change in payee should be initiated immediately by the facility.

NOTE: The facility shall allow the client to withdraw a minimum of $25 from his/her personal funds account on the date of discharge.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:688 (April 1999), repromulgated LR 31:2234 (September 2005).

§30717. Disposition of Deceased Client's Personal Funds

A. ICF/MRs, upon a client's death, shall submit written notification within 10 business days to the next of kin disclosing the amount of funds in the deceased's account as of the date of death. The ICF/MR shall hold the funds until the next of kin notifies the ICF/MR whether a succession will be opened.

1. Succession Opened. If a succession is to be opened, the ICF/MR shall release the funds to the administrator of the estate, if one, or according to the judgment of possession.

2. Succession Not Opened. If no succession is to be opened, the ICF/MR shall make the funds payable to the deceased's estate and shall release the funds to the responsible party of record.

B. Release of Funds. In any case in which funds are released in accordance with a court order, judgment of possession, or affidavit, the funds shall be made available to the persons or parties cited by the court order. The signed statement shall be attached to the written authority and filed in the ICF/MR records.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:688 (April 1999), repromulgated LR 31:2234 (September 2005).

§30719. Disposition of Deceased Client's Unclaimed Personal Funds

A. If the ICF/MR retains the funds and the responsible party (legal guardian, administrator of the estate, or person placed in possession by the court judgment) fails to obtain the funds within three months after the date of death, or if the ICF/MR fails to receive notification of the appointment of or other designation of a responsible party within three months after the death, the ICF/MR shall notify the secretary of the Department of Revenue, Unclaimed Property Section. The notice shall provide detailed information about the decedent, his next of kin, and the amount of funds.

1. The facility shall continue to retain the funds until a court order specifies that the funds are to be turned over to secretary of the Department of Revenue.

2. If no order or judgment is forthcoming, the ICF/MR shall retain the funds for five years after date of death.

3. After five years, the ICF/MR is responsible for delivering the unclaimed funds to the secretary of Revenue.

4. A termination date of the account and the reason for termination shall be recorded on the client's participation file. A notation shall read, "to close account." The endorsed canceled check with check number noted on the ledger sheet shall serve as sufficient receipt and documentation.

5. Where the legislature has enacted a law governing the disposition of personal funds belonging to residents of state schools for the mentally retarded or developmentally disabled that law shall be applicable.

B. References. References for §§30717 and 30719 are as follows:

1. *Civil Code* Article 2951 which deals with deposits of a deceased person;

2. *Code of Civil Procedure*, Articles 3421-3434, which deals with small successions requiring no judicial proceedings. Section 3431 specifically refers to persons who die intestate leaving no immovable property and whose sole heirs are his descendants, ascendants or surviving spouse.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:688 (April 1999), repromulgated LR 31:2234 (September 2005).

Subchapter B. Facility Records

§30739. General Requirements

A. The ICF/MR shall retain such records on file as required by DHH and shall have them available for inspection at request for three years from the date of service or until all audit exceptions are resolved, whichever period is longer.

B. Provider Agreement. The ICF/MR shall retain a copy of the Provider Agreement and any document pertaining to the licensing or certification of the ICF/MR.

C. Accounting Records

1. Accounting records must be maintained in accordance with generally accepted accounting principles as well as state and federal regulations. The accrual method of accounting is the only acceptable method for private providers.

NOTE: Purchase discounts, allowance and refunds will be recorded as a reduction of the cost to which they related.

2. Each facility must maintain all accounting records, books, invoices, canceled checks, payroll records, and other

documents relative to client care costs for a period of three years or until all audit exceptions are resolved, whichever period is longer.

3. All fiscal and other records pertaining to client care costs shall be subject at all times to inspection and audit by DHH, the legislative auditor, and auditors of appropriate federal funding agencies.

D. Daily Census Records. Each facility must maintain statistical information related to the daily census and/or attendance records for all clients receiving care in the facility.

E. Employee Records

1. The ICF/MR 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 criminal background check.

3. Verification of employee orientation and in-service training.

4. Verification of the employee's communicable disease screening.

F. Billing Records

1. The ICF/MR 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 ICF/MR shall maintain supporting fiscal documents and other records necessary to ensure that claims are made in accordance with federal and state requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, 42 CFR 433 and 42 CFR 442.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:690 (April 1999), repromulgated LR 31:2235 (September 2005).

Chapter 309. Transfers and Discharges

§30901. Written Agreements with Outside Resources

A. Each client must have the services which are required to meet his needs including emergency and other health care. If the service is not provided directly, there must be a written agreement with an outside resource. The written agreement for hospital transfers must be with hospitals within close proximity and must provide for prompt transfer of clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and CFR 483.410(d), 483.410(d)(1)-483.410(d)(2)(ii) and 483.440(b)(1)-483.440(b)(5)(ii).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:688 (April 1999), repromulgated LR 31:2235 (September 2005).

§30903. Facility Responsibilities for Planned or Voluntary Transfer or Discharge Policies

A. Facility record shall document that the client was transferred or discharged for good cause which means for any reason that is in the best interest of the individual.

B. Any decision to move a client shall be part of an interdisciplinary team process. The client, family, legal representative, and advocate, if there is one, shall participate in the decision making process.

C. Planning for a client's discharge or transfer shall allow for at least 30 days to prepare the client and parents/guardian for the change except in emergencies.

D. Planning for release of a client shall include providing for appropriate services in the client's new environment, including protective supervision and other follow-up services which are detailed in his discharge plan.

E. The client and/or legal representative must give their written consent to all nonemergency situations. Notification shall be made to the parents or guardians as soon as possible.

F. Both the discharging and receiving facilities shall share responsibility for ensuring the interchange of medical and other programmatic information which shall include:

1. an updated active treatment plan;

2. appropriate transportation and care of the client during transfer; and

3. the transfer of personal effects and of information related to such items;

G. Representatives from the staff of both the sending and receiving facilities shall confer as often as necessary to share appropriate information regarding all aspects of the client's care and habilitation training. The transferring facility is responsible for developing a final summary of the client's developmental, behavioral, social, health, and nutritional status, and with the consent of the client and/or legal

guardian, providing a copy to authorized persons and agencies.

H. The facility shall establish procedures for counseling clients or legal representatives, concerning the advantages and disadvantages of the possible release. This counseling shall include information regarding after care services available through agency and community resources.

I. All clients being transferred or discharged shall be given appropriate information about the new living arrangement. Counseling shall be provided if they are not in agreement. (See "Involuntary Transfers" if client is being transferred against his will).

J. The basic policy of client's right to the most appropriate placement which will meet his needs shall govern all transfer/discharge planning. Clients are not to be maintained in inappropriate placements or replacements in which their needs cannot adequately be met.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:689 (April 1999), repromulgated LR 31:2235 (September 2005).

§30905. Involuntary Transfer or Discharge

A. Conditions. Involuntary transfer or discharge of a client may occur only under the following conditions:

1. the transfer or discharge is necessary for the client's welfare and the client's needs cannot be met in the facility;

2. the transfer or discharge is appropriate because the client's health has improved sufficiently, therefore, the client no longer needs the services provided by the facility;

3. the safety of individuals in the facility is endangered;

4. the health of individuals in the facility would otherwise be endangered;

5. the client has failed, after reasonable and appropriate notice, to pay for the portion of the bill for services for which he/she is liable or when the client loses financial eligibility for Medicaid. When a client becomes eligible for Medicaid after admission to a facility, the facility may charge the client only allowable charges under Medicaid; and

6. the facility ceases to operate.

B. When the facility proposes to transfer or discharge a client under any of the circumstances specified in Paragraphs A.1-5 above, the client's clinical records must be fully documented. The documentation must be made by the following:

1. the client's physician when transfer or discharge is necessary as specified in Paragraph A.1 or 2 as listed above; or

2. any physician when transfer or discharge is necessary as specified in Paragraph A.4 as listed above. Before an interfacility transfer or discharge occurs the facility must:

a. notify the client of the transfer or discharge and the reason for the move. The notification shall be in writing and in a language and manner that the client understands. A copy of the notice must be placed in the client's clinical record and a copy transmitted to:

i. the client;

ii. a family member of the client, if known;

iii. the client's legal representative and legal guardian, if known;

iv. the Community Living Ombudsman Program;

v. DHH – Health Standards Section;

vi. the regional office of OCDD for assistance with the placement decision;

vii. the client's physician;

viii. appropriate educational authorities; and

ix. a representative of the client's choice;

b. record the reasons in the client's clinical record;

c. a interdisciplinary team conference shall be conducted with the client, family member or legal representative and an appropriate agency representative to update the plan and develop discharge options that will provide reasonable assurances that the client will be transferred or discharged to a setting that can be expected to meet his/her needs.

3. the facility must issue the notice of transfer or discharge in writing at least 30 days before the resident is transferred or discharged, except under the circumstances described in Subparagraph a below.

a. Notice may be made as soon as practicable before transfer or discharge when:

i. the safety of individuals in the facility would be endangered;

ii. the health of individuals in the facility would be endangered;

iii. the client's health improves sufficiently to allow a more immediate transfer or discharge; or

iv. an immediate transfer or discharge is required by the client's urgent medical needs as determined by a physician.

b. Notice may be made at least 15 days before transfer or discharge in cases of nonpayment of a bill for cost of care.

c. The written notice must include:

i. the reason for transfer or discharge;

ii. the effective date of transfer or discharge;

iii. the location to which the client is transferred or discharged;

iv. an explanation of the client's right to have personal and/or third party representation at all stages of the transfer or discharge process;

v. the address and telephone number of the Community Living Ombudsman Program;

vi.the mailing address and telephone number of the agency responsible for the protection of individuals with developmental disabilities;

vii. names of facility personnel available to assist the client and family in decision making and transfer arrangements;

viii. the date, time and place for the follow-up interdisciplinary team conference to make a final decision on the client's/legal representative's choice of new facility of alternative living arrangement;

ix. an explanation of the client's right to register a complaint with DHH within three days after the follow-up interdisciplinary team conference;

x. a statement regarding appeal rights that reads:

> "You or someone acting on your behalf has the right to appeal the health facility's decision to discharge you. The written request for a hearing must be postmarked within 30 days after you receive this notice or prior to the effective date of the transfer or discharge. If you request a hearing, it will be held within 30 days after the facility notifies the Bureau of Appeals of the witnesses who shall testify at the discharge hearing as well as the documents that will be submitted as evidence. You will not be transferred/discharged from the facility until a decision on the appeal has been rendered;" and

xi. the name of the director, and the address, telephone number, and hours of operation of the Bureau of Appeals of the Louisiana Department of Health and Hospitals;

C. The facility shall provide all services required prior to discharge that are contained in the final update of the individual habilitation plan and in the transfer or discharge plan.

D. The facility shall be responsible for keeping the client, whenever medical or other conditions warrant such action, for as long as necessary even if beyond the proposed date of transfer or discharge, except in emergency situations.

E. The facility shall provide transportation to the new residence unless other arrangements are preferred by the client/legal representative or the receiving facility.

F. Appeal of Transfer or Discharge. If the client appeals the transfer or discharge, the ICF/MR facility must permit the client to remain in the facility and must not transfer or discharge the client from the facility until the final appeal decision has been reached or a pre-hearing conference is held at the request of the facility. Failure to comply with these requirements will result in termination of the facility's provider agreement.

G. If nonpayment is the basis of a transfer or discharge, the client shall have the right to pay the balance owed to the facility up to the date of the transfer or discharge and then is entitled to remain in the facility.

H. If an ICF/MR client requests a hearing, the Louisiana Department of Health and Hospitals shall hold a hearing at the ICF/MR facility, or by telephone if agreed upon by the appellant, within 30 days from the date the appeal is filed with the Bureau of Appeals and witness and exhibit lists are submitted by the facility. The Louisiana Department of Health and Hospitals shall issue a decision within 30 days from the date of the client hearing. The ICF/MR facility must convince the department by a preponderance of the evidence that the transfer or discharge is justified. If the department determines that the transfer is appropriate and no appeal and/or pre-hearing conference has been lodged with the Bureau of Appeals, the client must not be required to leave the ICF/MR facility within 30 days after the client's receipt of the initial transfer or discharge notice unless an emergency exists.

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

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§30907. Mass Transfer of Clients

A. The following provisions shall apply to any mass transfer.

1. ICF/MR Decertification. When DHH/BHSF determines that an ICF/MR no longer meets state and federal Title XIX certification requirements, decertification action is taken. Usually an advance decertification date is set unless clients are in immediate danger.

2. ICF/MR Decertification Notice. On the date the ICF/MR is notified of its decertification, DHH shall begin notifying clients, families, responsible parties, and other appropriate agencies or individuals of the decertification action and of the services available to ensure an orderly transfer and continuity of care.

3. ICF/MR Closing or Withdrawing from Title XIX Program. In institutions where an ICF/MR either voluntarily or involuntarily discontinues its operations or participation in the Medical Assistance Program, clients, families, responsible parties, and other appropriate agencies or individuals shall be notified as far in advance of the effective date as possible to insure an orderly transfer and continuity of care.

a. If the ICF/MR is closing its operations, plans shall be made for transfer.

b. If the ICF/MR is voluntarily or involuntarily withdrawing from Title XIX participation, the client has the option of remaining in the ICF/MR on a private-pay basis.

4. Payment Limitation. Payments may continue for clients up to 30 days following the effective date of the ICF/MR's decertification.

a. There shall be no payments approved for Title XIX clients admitted after an ICF/MR receives a notice of decertification.

b. The payment limitation also applies to Title XIX clients admitted prior to the decertification notice.

c. Payment is continued to the ICF/MR for clients certified prior to the decertification only if the ICF/MR totally cooperates in the orderly transfer of clients to other Title XIX facilities or other placements of their choice.

NOTES:

The ICF/MR's failure to comply with the transfer team's requests may result in denial of reimbursement during the extension period.

The ICF/MR still retains its usual responsibility during the transfer/discharge process to notify the BHSF Medicaid Eligibility Parish Office promptly of all changes in the client's status.

5. Client Rights. Nothing in the transfer or discharge plan shall interfere with client's exercise of his rights.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:690 (April 1999), repromulgated LR 31:2237 (September 2005).

Chapter 311. Health Services

§31101. Client Health and Habilitative Services

A. *Intermediate Care Facilities for the Mentally Retarded (ICF/MR)* are defined as intermediate care facilities whose primary purpose is to provide health or habilitative services for mentally retarded individuals or persons with related conditions and meet the standards in 42 CFR 442 and 483.400.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:691 (April 1999), repromulgated LR 31:2238 (September 2005).

§31103. Habilitative Treatment Services

A. Active Treatment Services. The facility must provide or arrange for each client to receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual habilitation plan (IHP). These services include but are not limited to occupational, speech, physical and recreational therapies; psychological, psychiatric, audiology, social work, special education, dietary and rehabilitation counseling.

NOTE: Supplies, equipment, etc., needed to meet the goals of the IHP cannot be charged to the client or their responsible parties.

B. Active Treatment Components

1. Individual Habilitation Plan. Each client must have an individual habilitation plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to identifying the client's needs as described by the programs that meet those needs.

a. The facility must document in the individual habilitation plan (IHP) the presence, or the reason for absence, at the individual's staffing conference of the client, family members and relevant disciplines, professions or service areas as identified in the comprehensive functional assessment.

b. Within 30 days after admission, the interdisciplinary team must do assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.

c. The comprehensive functional assessment must take into consideration the client's age and the implications for active treatment at each stage as applicable. It must contain the following components:

i. the presenting problems and disabilities and where possible, their causes including diagnosis, symptoms, complaints and complications;

ii. the client's specific developmental strengths;

iii. the client's specific developmental and behavioral management needs.

d. An identification of the client's needs for services without regard to the actual availability of the services.

e. The comprehensive functional assessment must cover the following developmental areas:

i. physical development and health;

ii. nutritional status;

iii. sensorimotor development;

iv. affective development;

v. speech and language development;

vi. auditory functioning;

vii. cognitive development;

viii. social development;

ix. adaptive behaviors or independent living skills necessary for the client to be able to function in the community;

x. vocational skills as applicable;

xi. psychological development.

2. Specific Objectives. Within 30 days after admission, the interdisciplinary team must prepare for each client an IHP that states specific objectives necessary to meet the client's needs, as identified by the comprehensive functional assessment, and states the plan for achieving these objectives.

a. Components for these objectives must be:

i. stated separately, in terms of a single behavioral outcome;

ii. be assigned projected completion dates;

iii. be expressed in behavioral terms that provide measurable indices of performance;

iv. be organized to reflect a developmental disability;

v. be assigned priorities.

b. A copy of each client's individual habilitation plan must be made available to all relevant staff, including staff of other agencies who work with the client, the client, parents, if the client is a minor, or legal guardian. The individual's habilitation plan must be implemented within 14 calendar days of its development.

c. The facility must develop and make available to relevant staff an active treatment schedule that outlines the current active treatment program.

d. Each written training program designed to implement these objectives in the individual habilitation plan must specify:

i. the methods to be used;

ii. the schedule for use of the methods;

iii. the person responsible for the program;

iv. the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;

v. the inappropriate client behavior(s), if applicable; and

vi. a provision for the appropriate expression and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

e. The IHP must also:

i. describe relevant interventions to support the individual toward independence;

ii. identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found;

iii. include, for those clients who lack them, training in personal skills essential for privacy and independence (including skills and activities of daily living) until it has been demonstrated that the client is developmentally incapable of applying them;

iv. plans for discharge.

f. The IHP must identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. This plan must specify:

i. the reason for each support;

ii. the situation in which each is to be applied;

iii. a schedule for the use of each support.

g. Clients who have multiple disabling conditions must be provided the opportunity to spend a major portion of each working day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

h. The IHP must include opportunities for client choice and self management.

3. Documentation. The facility must document data relevant to the accomplishment of the criteria specified in the client's individual habilitation plan objectives. This data must meet certain criteria.

a. Data must be documented in measurable outcomes;

b. Significant events related to the client's individual habilitation plan and assessment and that contribute to an overall understanding of his ongoing level and quality of function must be documented;

c. The individual habilitation plan must be reviewed by a qualified mental retardation professional at least quarterly or as needed and revised as necessary, including but not limited to, situations in which the client:

i. has successfully completed an objective or objectives identified in the individual habilitation plan;

ii. is regressing or losing skills;

iii. is failing to progress toward identified objectives after reasonable efforts have been made;

iv. is being considered for training toward new objectives.

d. At least annually, the comprehensive assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. The individual habilitation plan must be revised as needed or at least by the three hundred sixty-fifth day after the last review.

NOTE: For admission requirements, refer to Chapter 303, Provider Enrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR

13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:691 (April 1999), repromulgated LR 31:2238 (September 2005).

§31105. Professional Services

A. Physician Services

1. The health care of each client shall be under the continuing supervision of a Louisiana licensed physician. The facility must ensure the availability of physician services 24 hours a day. The facility must provide or obtain preventive and general medical care plus annual physical examinations of each client.

2. The client, the family or the responsible party shall be allowed a choice of physicians.

3. If the client does not have a personal physician, the ICF/MR shall provide referrals to physicians in the area, identifying physicians that participate in the Medicaid Program.

NOTE: The cost of physician services cannot be charged to the client or their responsible parties.

B. Nursing Services

NOTE: The cost for nursing services cannot be charged to the client or their legal representative.

1. The facility must provide each client nursing services as prescribed by a physician or as identified by the individual habilitation plan and client needs. Nursing services must include:

a. the development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan;

b. twenty-four-hour nursing service as indicated by the medical care plan or other nursing care as prescribed by the physician or as identified by client needs;

c. review of individual client health status on a quarterly or more frequent basis;

d. training clients and staff as needed in appropriate health and hygiene methods and self-administration of medications;

e. notify the physician of any changes in the client's health status.

2. If the facility utilizes only licensed practical nurses to provide health services, it must have a formal arrangement with a registered nurse licensed to practice in Louisiana to be available for verbal or on-site consultation to the licensed practical nurse.

C. Dental Services. The facility must provide or arrange for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement. The facility must ensure that dental treatment services include dental care needed for relief of pain and infections, restoration of teeth and maintenance of dental health. The facility must ensure the availability of emergency treatment on a 24-hour per day basis by a licensed dentist.

NOTE: The cost for these dental services cannot be charged to the client or their responsible party.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:691 (April 1999), repromulgated LR 31:2239 (September 2005).

§31107. Pharmaceutical Services

A. The facility must provide or arrange for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

B. Routine administration of medications shall be done at the facility where the client resides. Clients may not be transported elsewhere for the sole purpose of medication administration.

C. The ICF/MR shall neither expect, nor require, any provider to give a discount or rebate for prescription services rendered by the pharmacists.

D. The ICF/MR shall order at least a one month supply of medications from a pharmacy of the client's, family's, or responsible party's choice. Less than a month's supply is ordered only when the attending physician specifies that a smaller quantity of medication is necessary for a special medical reason.

E. The ICF/MR chief executive officer or the authorized representative shall certify receipt of prescribed medications by signing and dating the pharmacy billing.

NOTE: The costs for drugs and biologicals cannot be charged to the client, family or responsible party including any additional charges for the use of the unit dose or blister pack system of packing and storing medications.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:691 (April 1999), repromulgated LR 31:2240 (September 2005).

§31109. Aids and Equipment

A. The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

NOTE: The costs for aids and equipment cannot be charged to the clients or their legal representatives.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:691 (April 1999), repromulgated LR 31:2240 (September 2005).

§31111. Nutritional Services

A. The facility must provide a nourishing, well-balanced diet for each client, including modified and specially prescribed diets. The nutritional component must be under the guidance of a licensed dietitian.

NOTE: Nutritional services are included in the per diem rate. Residents of ICF/MR facilities are not eligible for food stamps, commodities, or other subsidized food programs.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:691 (April 1999), repromulgated LR 31:2240 (September 2005).

§31113. Clothing

A. The facility should provide adequate seasonal clothing for the client. *Adequate* is defined as a seven-day supply in good repair and properly fitting. Work uniforms or special clothing/equipment for training will be provided in addition to the seven-day supply.

B. The facility must maintain a current clothing inventory for each client.

1. A client with adequate clothing may purchase additional clothing using his/her personal funds if he/she desires.

2. If a client desires to purchase a certain brand, the client has the right to use his/her personal funds in this manner; however, the client must be made aware of what the facility is providing prior to making his/her decision.

NOTE: For more information on services that must be provided by the ICF/MR facility or may be purchased by the client, see §33101, Income Consideration in Determining Payment.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:691 (April 1999), repromulgated LR 31:2240 (September 2005).

Chapter 313. Client Behavior Management

§31301. Written Policies and Procedures

A. A facility must develop and implement written policies and procedures for the management of conduct between staff and clients. These policies and procedures will:

1. specify conduct to be allowed and not allowed by staff and/or clients;

2. provide for client choice and self determination to the extent possible;

3. be readily available to all clients, parent(s), staff, and legal guardians;

4. be developed with the participation of clients to the extent possible.

B. A facility must develop and implement written policies and procedures for the management of inappropriate client behavior. These policies and procedures must:

1. specify all facility approved interventions to manage inappropriate client behavior;

2. designate these interventions on a hierarchy ranging from the most positive and least restrictive to the least positive and most restrictive;

3. insure that, prior to the use of more restrictive techniques, the client's record document that programs incorporating the use of less intrusive or more positive techniques have been tried first and found to be ineffective;

4. address the use of:

a. time-out rooms;

b. physical restraints;

c. drugs used to manage inappropriate behavior;

d. application of painful or noxious stimuli;

e. the staff members who may authorize use of a particular intervention;

f. a mechanism for monitoring and controlling use of the intervention.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40.2009.2, R.S. 40:2009.20, R.S. 403.2, 42 CFR 483.420, 483.440, and 483.450.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:693 (April 1999), repromulgated LR 31:2240 (September 2005).

§31303. Interventions to Manage Inappropriate Client Behavior

A. Safety and Supervision. Interventions to manage inappropriate client behavior must be used within sufficient safeguards and supervision to insure that the safety, welfare, and civil and human rights of clients are adequately protected. These interventions must:

1. never be used:

a. for disciplinary purposes;

b. for the convenience of staff; or

c. as a substitute for an active treatment program;

2. never include corporal punishment;

3. never include discipline of one client by another except as part of an organized system of self government as set forth in facility policy.

B. Individual Plans and Approval. Individual programs to manage inappropriate client behavior must be incorporated into the client's individual program plan and must be reviewed, approved, and monitored by the Specially Constituted Committee. Written informed consent by the client or legal representative is required prior to implementation of a behavior management plan involving any risks to client's rights. (See Chapter 315, Client Rights, which addresses informed consent.)

C. Standing Programs. Standing or as needed programs to control inappropriate behavior are not permitted. To send a client to his room when his behavior becomes inappropriate is not acceptable unless part of a systematic program of behavioral interventions for the individual client.

D. Time-out Rooms

1. Use of time-out rooms is not permitted in group or community homes.

2. In institutional settings, it is permitted only when professional staff is on-site and only under the following conditions:

a. the placement in a time-out room is part of an approved systematic behavior program as required in the individual program to manage inappropriate behavior discussed under §31303.A.1-3; emergency placement is not allowed;

b. the client is under direct constant visual supervision of designated staff;

c. if the door to the room is closed, it must be held shut only by use of constant physical pressure from a staff member;

d. placement in time-out room does not exceed one hour;

e. clients are protected from hazardous conditions while in time-out rooms;

f. a record is kept of time-out activities.

E. Physical Restraint. *Physical restraint* is defined as any manual method or physical or mechanical device that the individual cannot remove easily and which restricts free movement.

1. Examples of manual methods include:

a. therapeutic or basket holds; and

b. prone or supine containment.

2. Examples of physical or mechanical devices include:

a. barred enclosure which must be no more than 3 feet in height and must not have tops;

b. chair with a lap tray used to keep an ambulatory client seated;

c. wheelchair tied to prevent movement of a wheelchair mobile client;

d. straps used to prevent movement while client is in chair or bed.

3. Physical restraints can be used only:

a. when absolutely necessary to protect the client from injuring himself or others in an emergency situation;

b. when part of an individual program plan intended to lead to less restrictive means of managing the behavior the restraints are being used to control;

c. as a health related protection prescribed by a physician but only if absolutely necessary during a specific medical, dental, or surgical procedure or while a medical condition exists;

d. when the following conditions are met:

i. orders for restraints are not obtained for use on a standing or on an as needed basis;

ii. restraint authorizations are not in effect longer than 12 consecutive hours and are obtained as soon as possible after restraint has occurred in emergency situations;

iii. clients in restraints are checked at least every 30 minutes and released as quickly as possible. Record of restraint checks and usage is required;

iv. restraints are designed and used so as not to cause physical injury and so as to cause the least possible discomfort;

v. opportunities for motion and exercise are provided for not less than 10 minutes during each two-hour period and a record is kept; and

vi. restraints are applied only by staff who have had training in the use of these interventions.

F. Drugs. Drugs used for control of inappropriate behavior may be used only under the following conditions:

1. drugs must be used only in doses that do not interfere with the client's daily living activities;

2. drugs used for control of inappropriate behavior must be approved by the interdisciplinary team, the client, legal representative, and specially constituted committee. These drugs must be used only as part of the client's individual program plan that is directed toward eliminating the behavior the drugs are thought to control;

3. prior to the use of any program involving a risk to client protection and rights, including the use of drugs to manage inappropriate behavior, written informed consent must be obtained from:

a. client; or

b. family, legal representative, or advocate if client is a minor or client is mentally unable to understand the intended program or treatment;

4. informed consent consists of permission given voluntarily on a time limited basis not to exceed 365 days by the client or the legally appropriate party after having been informed of the:

a. specific issue treatment or procedure;

b. client's specific status with regard to the issue;

c. attendant risks regarding the issue;

d. acceptable alternatives to the issue;

e. right to refuse;

f. consequences of refusal;

5. drugs must not be used until it can be justified that the beneficial effects of the drug on the client's behavior clearly outweighs the potentially harmful effects of the drug;

6. drugs must be clearly monitored in conjunction with the physician, the pharmacist, and facility staff;

7. unless clinical evidence justifies that this is contraindicated, drugs for control of inappropriate behavior must be gradually reduced at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40.2009.2, R.S. 40:2009.20, R.S. 403.2, 42 CFR 483.420, 483.440, and 483.450.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:693 (April 1999), repromulgated LR 31:2241 (September 2005).

Chapter 315. Client Rights

§31501. Written Policies

A. The ICF/MR will establish written policies that safeguard clients' rights and define their responsibilities. The ICF/MR chief executive officer and ICF/MR staff will be trained in, and will adhere to, client rights policies and procedures. ICF/MR personnel will protect and promote clients' civil rights and rights to a dignified existence, self-determination, communication with and access to persons and services inside and outside the facility and to exercise their legal rights. The chief executive officer will be responsible for staff compliance with client rights policies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 28.390, 42 CFR 483.420 and 483.410 (1), (2), (3), Title XIX of the Social Security Act, Section 601 of Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; and Age Discrimination Act of 1975.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:694 (April 1999), repromulgated LR 31:2242 (September 2005).

§31503. Notification of Rights

A. All clients, families, and/or responsible parties will sign a statement that they have been fully informed verbally and in writing of the following information at the time of admission and when changes occur during the client's stay in the facility:

1. the facility's rules;

2. their rights;

3. their responsibilities to obey all reasonable rules and respect the personal rights and private property of clients; and

4. rules for conduct at the time of their admissions and subsequent changes during their stay in the facility.

B. Changes in client right policies will be conveyed both verbally and in writing to each client, family, and/or responsible party at the time of or before the change.

C. Receipt of the change will be acknowledged in writing by:

1. each client who is capable of doing so;

2. client’s family; and/or

3. responsible party.

D. A client's written acknowledgment will be witnessed by a third person.

E. Each client must be fully informed in writing of all services available in the ICF/MR and of the charges for these services including any charges for services not paid for by Medicaid or not included in the facility's basic rate per day charges. The facility must provide this information either before or at the time of admission and on a continuing basis as changes occur in services or charges during the client's stay.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 28.390, 42 CFR 483.420 and 483.410 (1), (2), (3), Title XIX of the Social Security Act, Section 601 of Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; and Age Discrimination Act of 1975.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:694 (April 1999), repromulgated LR 31:2242 (September 2005).

§31505. Statute Authority

A. Civil Rights Act of 1964 (Title VI). Title VI of the Civil Rights Act of 1964 states: "No persons in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.” The facility will meet the following criteria in regards to the above-mentioned Act.

1. Compliance. The facility will be in compliance with Title VI of the Civil Rights Act of 1964 and will not

discriminate, separate, or make any distinction in housing, services, or activities based on race, color, or national origin.

2. Written Policies. The facility will adopt and implement written policies for compliance with the Civil Rights Act. All employees and contract service providers who provide services to clients will be notified in writing of the Civil Rights policy.

3. Community Notification. The facility will notify the community that admission to the ICF/MR, services to clients, and other activities are provided without regard to race, color, or national origin.

a. Notice to the community may be given by letters to and meetings with physicians, local health and welfare agencies, paramedical personnel, and public and private organizations having interest in equal opportunity.

b. Notices published in newspapers and signs posted in the facility may also be used to inform the public.

4. Housing. All clients will be housed without regard to race, color, or national origin.

a. ICF/MRs will not have dual accommodations to effect racial segregation.

b. Biracial occupancy of rooms on a nondiscriminatory basis will be required. There will be a policy prohibiting assignment of rooms by race.

c. Clients will not be asked if they are willing to share a room with a person of another race, color, or national origin.

d. Client transfer will not be used to evade compliance with Title VI of the Civil Rights Act of 1964.

5. Open Admission Policy. An open admission policy and desegregation of ICF/MR will be required, particularly when the facility previously excluded or primarily serviced clients of a particular race, color, or national origin. Facilities that exclusively serve clients of one race have the responsibility for taking corrective action, unless documentation is provided that this pattern has not resulted from discriminatory practices.

6. Client Services. All clients will be provided medical, nonmedical, and volunteer services without regard to race, color, or national origin. All administrative, medical and nonmedical services are covered by this requirement.

7. All ICF/MR staff will be permitted to provide client services without regard to race, color, or national origin.

a. Medical, paramedical, or the professional persons, whether engaged in contractual or consultative capacities, will be selected and employed in a nondiscriminatory manner.

b. Opportunity for employment will not be denied to qualified persons on the basis of race color, or national origin.

c. Dismissal from employment will not be based upon race, color, or national origin.

B. Rehabilitation Act of 1973—Section 504. Facilities will comply with Section 504 of the Rehabilitation Act of 1973 that states: "No qualified person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance."

C. Age Discrimination Act of 1975. This Act prohibits discrimination on the basis of age in programs or activities receiving federal financial assistance. All ICF/MRs must be in compliance with this Act.

D. Americans with Disabilities Act of 1990. All ICF/MR facilities must be in compliance with this Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 28.390, 42 CFR 483.420 and 483.410 (1), (2), (3), Title XIX of the Social Security Act, Section 601 of Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; and Age Discrimination Act of 1975.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:694 (April 1999), repromulgated LR 31:2242 (September 2005).

§31507. Client Rights

A. The facility must comply with 42 CFR 483.420 and with the provisions below.

1. Each client must:

a. be fully informed by a physician of his health and medical condition unless the physician decides that informing the client is medically contraindicated;

b. be given the opportunity to participate in planning his total care and medical treatment;

c. be given the opportunity to refuse treatment; and

d. give informed, written consent before participating in experimental research.

2. If the physician decides that informing the client of his health and medical condition is medically contraindicated, he must document this decision in the client's record.

3. Each client must be transferred or discharged only in accordance with the discharge plans in the IHP (see Chapter 311, Health Services).

4. Each client must be:

a. encouraged and assisted to exercise his rights as a client of the facility and as a citizen; and

b. allowed to submit complaints or recommendations concerning the policies and services of the ICF/MR to staff or to outside representatives of the client's choice or both, free from restraining, interference, coercion, discrimination, or reprisal. This includes the right to due process.

5. Each client must be allowed to manage his personal financial affairs and taught to do so to the extent of individual capability. If a client requested assistance from the facility in managing his personal financial affairs:

a. the request must be in writing; and

b. the facility must comply with the record keeping requirements of Chapter 307, Subchapters A and B, Client Records and Facility Records.

6. Freedom from Abuse and Restraints

a. Each client must be free from physical, verbal, sexual or psychological abuse or punishment.

b. Each client must be free from chemical and physical restraints unless the restraints are used in accordance with §31303, Interventions to Manage Inappropriate Client Behavior.

7. Privacy

a. Each client must be treated with consideration, respect, and full recognition of his dignity and individuality.

b. Each client must be given privacy during treatment and care of personal needs.

c. Each client's records, including information in an automatic data base, must be treated confidentially.

d. Each client must give written consent before the facility may release information from his record to someone not otherwise authorized by law to receive it.

e. A married client must be given privacy during visits by his spouse.

NOTE: If both husband and wife are residents of the facility, they must be permitted to share a room.

8. No client may be required to perform services for the facility. Those clients who by choice work for the facility must be compensated for their efforts at prevailing wages and commensurate with their abilities.

9. Each client must be allowed to:

a. communicate, associate, and meet privately with individuals of his choice, unless this infringes on the rights of another client;

b. send and receive personal mail unopened; and

c. have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within his individual program plan.

10. Each client must be allowed to participate in social, religious, and community group activities.

11. Each client must be allowed to retain and use his personal possessions and clothing as space permits.

12. Each client may be allowed burial insurance policy(s). The facility administrator or designee, with the client's permission, may assist the resident in acquiring a burial policy, provided that the administrator, designee, or affiliated persons derive no financial or other benefit from the resident's acquisition of the policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 483.420.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:694 (April 1999), repromulgated LR 31:2243 (September 2005).

§31509. Violation of Rights

A. A person who submits or reports a complaint concerning a suspected violation of a client's rights or concerning services or conditions in an ICF/MR or who testifies in any administrative or judicial proceedings arising from such complaints will have immunity from any criminal or civil liability therefore, unless that person has acted in bad faith with malicious purpose, or if the court finds that there was an absence of a justifiable issue of either law or fact by the complaining party.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 483.420.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:694 (April 1999), repromulgated LR 31:2244 (September 2005).

Chapter 317. Complaints

§31701. Purpose and Scope

A. Under the provisions of Louisiana R.S. 40:2009.13-40:2009.20 and 14:4032 federal regulation 42 CFR 483.405, 483.420, 483.440 and the state Operations Manual published by the Department of Health and Hospitals and Health Care Financing Administration, the following procedures are established for receiving, evaluating, investigating, and correcting grievances concerning client care in ICF/MR licensed and certified ICF/MR facilities. The procedures in this Chapter 317 also provide mandatory reporting of abuse and neglect in ICF/MR facilities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2009.13, R.S. 40:2009.20, R.S. 14:4032, Title XIX of the Social Security Act, 42 CFR 483.405, 483.420, and 483.440.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:696 (April 1999), repromulgated LR 31:2244 (September 2005).

§31703. Applicability

A. Any person having knowledge of the alleged abuse or neglect of a client or knowledge of a client being denied care and treatment may submit a complaint, preferably in writing.

B. Any person may submit a complaint if he/she has knowledge that a state law, standard, rule, correction order, or certification rule issued by the Department of Health and Hospitals has been violated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2009.13, R.S. 40:2009.20, R.S. 14:4032, Title XIX of the Social Security Act, 42 CFR 483.405, 483.420, and 483.440.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:696 (April 1999), repromulgated LR 31:2244 (September 2005).

§31705. Duty to Report

A. All incidents or allegations of abuse and/or neglect must be reported by telephone or fax within 24 hours to DHH's Health Standards Section. This must be followed by a copy of the results of the facility's internal investigation within five working days. Complete investigative reports with all pertinent documents shall be maintained at the facility. Failure to submit this information timely could result in a deficiency and/or a sanction. Those who must make a report of abuse and/or neglect are:

1. physicians or other allied health professionals;
2. social services personnel;
3. facility administration;
4. psychological or psychiatric treatment personnel;
5. registered nurses;
6. licensed practical nurses; and
7. direct care staff.

B. Penalties for Failure to Make Complaint. Any person who knowingly and willfully fails to report an abuse or neglect situation shall be fined not more than $500 or imprisoned not more than two months or both. The same sanctions shall apply to an individual who knowingly and willingly files a false report. Penalties for committing cruelty or negligent mistreatment to a resident of a health care facility shall be not more than $10,000 or imprisoning with or without hard labor for more than 10 years, or both.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2009.13, R.S. 40:2009.20, R.S. 14:4032, Title XIX of the Social Security Act, 42 CFR 483.405, 483.420, and 483.440.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:696 (April 1999), repromulgated LR 31:2244 (September 2005).

§31707. Where to Submit Complaint

A. A complaint can be filed as follows:

1. it may be submitted in writing to the Health Standards Section at Box 3767, Baton Rouge, LA 70821-3767; or

2. it may be made by calling Health Standards Section at 1-888-810-1819, or (225) 342-0082, and the FAX number (225) 342-5292;

3. in addition, it may be submitted to any local law enforcement agency.

B. DHH's Referral of Complaints for Investigation

1. Complaints involving clients of ICF/MRs received by DHH shall be referred to the Health Standards Section.

2. If it has been determined that complaints involving alleged violations of any criminal law concerning a facility are valid, the investigating office of DHH shall furnish copies of the complaints for further investigation to the Office of the Attorney General, Medicaid Fraud Control Unit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2009.13, R.S. 40:2009.20, R.S. 14:4032, Title XIX of the Social Security Act, 42 CFR 483.405, 483.420, and 483.440.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:696 (April 1999), repromulgated LR 31:2244 (September 2005).

§31709. Disposition of Complaints

A. After the investigation DHH may take any of the following actions.

1. Valid Complaint with Deficiencies Written. The Department of Health and Hospitals shall notify the administrator who must provide an acceptable plan of correction as specified below.

a. If it is determined that a situation presents a threat to the health and safety of the client, the facility shall be required to take immediate corrective action. DHH may certify noncompliance, revoke or suspend the license, or impose sanctions.

b. In all other instances of violation, an expeditious correction, not to exceed 90 days, shall be required. If the provider is unable or unwilling to correct the violation, DHH may take any of the actions listed in Subparagraph 1.a.

c. In cases of abuse and/or neglect, referral for appropriate corrective action shall be made to the Office of the Attorney General, Medicaid Fraud Control Unit.

2. Unsubstantiated Complaint. DHH shall notify the complainant and the facility of this finding.

3. Repeat Violations. When violations continue to exist after the corrective action was taken, the Department of Health and Hospitals may take any of the actions listed in Subparagraph 1.a.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2009.13, R.S. 40:2009.20, R.S. 14:4032, Title XIX of the Social Security Act, 42 CFR 483.405, 483.420, and 483.440.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:696 (April 1999), repromulgated LR 31:2245 (September 2005).

§31711. Informal Reconsideration

A. A complainant or a facility dissatisfied with any action taken by DHH's response to the complaint

investigation may request an informal reconsideration as provided in R.S. 40:2009.11 et seq.

B. Retaliation by ICF/MR Facility. Facilities are prohibited from taking retaliatory action against complainants. Persons aware of retaliatory action or threats in this regard should contact DHH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2009.13, R.S. 40:2009.20, R.S. 14:4032, Title XIX of the Social Security Act, 42 CFR 483.405, 483.420, and 483.440.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:696 (April 1999), repromulgated LR 31:2245 (September 2005).

§31713. Tracking Incidents

A. For each client who is involved in an accident or incident, an incident report shall be completed including the name, date, time, details of accident or incident, circumstances under which it occurred, witnesses and action taken.

1. Incidents or accidents involving clients must be documented in the client's record. These records should also contain all pertinent medical information.

2. The examples listed below are not all inclusive, but are presented to serve as a guideline to assist those facility employees responsible for reporting incident reports.

a. Suspicious Death. Death of a client or on-duty employee when there is suspicion of death other than by natural causes.

b. Abuse and/or Neglect. All incidents or allegations of abuse and/or neglect.

c. Runaways. Runaways considered dangerous to self or others.

d. Law Enforcement Involvement. Arrest, incarceration, or other serious involvement of residents with law enforcement authorities.

e. Mass Transfer. The voluntary closing of a facility or involuntary mass transfer of residents from a facility.

f. Violence. Riot or other extreme violence.

g. Disasters. Explosions, bombings, serious fires.

h. Accidents/Injuries. Severe accidents or serious injury involving residents or on-duty employees caused by residents such as life threatening or possible permanent and/or causing lasting damage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2009.13, R.S. 40:2009.20, R.S. 14:4032, Title XIX of the Social Security Act, 42 CFR 483.405, 483.420, and 483.440.

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Chapter 319. Utilization Review

§31901. Utilization Review

A. If it is determined by HSS that continued stay is not needed, the client's attending physician or qualified mental retardation professional (QMRP) shall be notified within one working day and given two working days from the notification date to present his/her views before a final decision on continued stay is made.

B. If the attending physician or QMRP does not present additional information or clarification of the need for continued stay, the decision of the utilization review (UR) group is final.

C. If the attending physician or QMRP presents additional information or clarification, the need for continued stay is reviewed by the physician member(s) of the UR group in cases involving a medical determination.

D. The decision of the UR group is the final medical eligibility decision. Recourse for the client is to exercise his/her appeal rights according to the Administrative Procedure Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 456.350 through 456.438.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:700 (April 1999), repromulgated LR 31:2245 (September 2005).

Chapter 321. Appeals

§32101. Administrative Appeals

A. DHH reserves the right to reject a request for Title XIX participation, impose sanctions or terminate participation status when an ICF/MR:

1. fails to abide by the rules promulgated by DHH;

2. fails to obtain compliance or is otherwise not in compliance with Title VI of the Civil Rights Act;

3. engages in practice not in the best interest of Medicaid (Title XIX) clients;

4. has previously been sanctioned for violation of state and/or federal rules; or

5. has previously been decertified from participation as a Title XIX provider. Prior to such rejection or termination, DHH may conduct an Informal Reconsideration at the ICF/MR's request. The ICF/MR also has the right to an administrative appeal pursuant to the Administrative Procedure Act.

B. Informal Reconsideration. When an ICF/MR receives a written notification of adverse action and a copy of the findings upon which the decision was based, the ICF/MR may provide written notification to BHSF/HSS within 10

calendar days of receiving the notification, and request an Informal Reconsideration.

1. The ICF/MR may submit written documentation or request an opportunity to present oral testimony to refute the findings of DHH on which the adverse action is based.

2. DHH will review all oral testimony and documents presented by the ICF/MR and, after the conclusion of the Informal Reconsideration, will advise the ICF/MR in writing of the results of the reconsideration which may be that:

a. the original decision has been upheld;

b. the original decision has been modified; or

c. the original decision has been reversed.

C. Evidentiary HearingXGeneral Requirements. The ICF/MR may also request an administrative appeal. To request such an appeal, the facility must submit their request, in writing, within 30 days of the receipt of the adverse action to the Bureau of Appeals, Box 4183, Baton Rouge, LA 70821-4183. The Bureau of Appeals will attempt to conduct the hearing within 120 days of the original notice of adverse action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 431.151 - 431.154.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:700 (April 1999), repromulgated LR 31:2246 (September 2005).

§32103. Notice and Appeal Procedure

A. When DHH imposes a sanction on a health care provider, it will give the provider written notice of the imposition. The notice will be given by certified mail and will include the following:

1. the nature of the violation(s) and whether the violation(s) is classified as a repeat violation;

2. the legal authority that established the violation(s);

3. the civil fine assessed for each violation;

4. inform the administrator of the facility that the facility has 10 days from receipt of the notice within which to request an informal reconsideration of proposed sanction;

5. inform the administrator of the facility that the facility has 30 days from receipt of the notice within which to request an administrative appeal of the proposed sanction and that the request for an informal reconsideration does not extend the time limit for requesting an administrative appeal; and

6. inform the administrator of the facility that the consequences of failing to request an informal reconsideration and/or an administrative appeal will be that DHH's decision is final and that no further administrative or judicial review may be had.

B. The provider may request an informal reconsideration of DHH's decision to impose a civil fine. This request must be written and made to DHH within 10 days of receipt of the notice of the imposition of the fine.

1. This reconsideration will be conducted by designated employees of DHH who did not participate in the initial decision to recommend imposition of a sanction.

2. Oral presentation can be requested by the provider representative, and if requested, will be made to the designated employees.

3. Reconsideration will be made on the basis of documents and oral presentations made by the provider to the designated employees at the time of the reconsideration.

4. Correction of the deficient practice for which the sanction was imposed will not be the basis of the reconsideration.

5. The designated employees will only have the authority to confirm, reduce or rescind the civil fine.

6. DHH will notify the provider of the results of the reconsideration within 10 working days after the oral presentation.

7. This process is not in lieu of the administrative appeal and does not extend the time limits for filing an administrative appeal.

C. The facility may request an administrative appeal. If an administrative appeal is requested in a timely manner, the appeal will be held as provided in the Administrative Procedure Act (R.S. 49:950 et seq.) An appeal bond will be posted with the Bureau of Appeals as provided in R.S. 40:2199(D) or the provider may choose to file a devolutive appeal. A devolutive appeal means that the civil fine must be paid in full within 10 days of filing the appeal.

D. The provider may request judicial review of the administrative appeal decision as provided in the Administrative Procedure Act.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:701 (April 1999), repromulgated LR 31:2046 (September 2005).

§32105. Collection of Fines

A. Fines are final when:

1. an appeal is not requested within the specified time limits;

2. the facility admits the violations and agrees to pay the fine; or

3. the administrative hearing affirms DHH's findings of violations and time for seeking judicial review has expired.

B. When civil fines become final, they will be paid in full within 10 days of their commencement unless DHH allows a payment schedule in light of documented financial hardship. Arrangements with DHH for a payment schedule must commence within 10 days of the fines becoming final. Interest will begin to accrue at the current judicial rate on the day the fines become final.

C. If payment of assessed fines is not received within the prescribed time period after becoming final and the provider is a Medicaid provider, DHH will deduct the full amount plus the accrued interest from money otherwise due to the provider as Medicaid reimbursement in its next (quarterly or monthly) payment. If the provider is not a Medicaid provider, DHH will institute civil actions as necessary to collect fines due.

D. No provider may claim imposed fines or interest as reimbursable costs, nor increase charges to residents, clients, or patients as a result of such fines or interest.

E. Civil fines collected will be deposited in the Health Care Facility Fund maintained by the state treasury.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:701 (April 1999), repromulgated LR 31:2246 (September 2005).

Chapter 323. Sanctions

§32301. Noncompliance

A. When ICF/MRs are not in compliance with the requirements set forth in the ICF/MR Standards for Payment, DHH may impose sanctions. Sanctions may involve:

1. withholding of vendor payments;

2. civil fines;

3. denial of payments for new admissions; or

4. nonfinancial measures such as termination of the ICF/MR's certification as a Title XIX provider.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:701 (April 1999) repromulgated LR 31:2247 (September 2005).

§32303. Authority

A. Public Law 95-142, dated October 25, 1977, permits the federal government's Health Care Financing Administration (HCFA) to impose a fine and/or imprisonment of facility personnel for illegal admittance and retention practices. HCFA is also authorized to terminate an agreement with a Title XIX ICF/MR provider as a result of deficiencies found during their surveys, which are re-reviews of the state's surveys. Furthermore, the federal government's Office of Inspector General (OIG) is authorized to terminate an agreement with a Title XIX ICF/MR provider for willful misrepresentation of financial facts or for not meeting professionally recognized standards of health care.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:701 (April 1999), repromulgated LR 31:2249 (September 2005).

§32305. Special Staffing

A. When the secretary of DHH determines that additional staffing or staff with specific qualifications would be beneficial in correcting deficient practices, DHH may require a facility to hire additional staff on a full-time or consultant basis until the deficient practices have been corrected. This provision may be invoked in concert with, or instead of, the sanctions cited in §32307.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:701 (April 1999), repromulgated LR 31:2247 (September 2005).

§32307. Withholding of Vendor Payments

A. Withholding of Vendor Payments. DHH may withhold vendor payments in whole or in part in the following situations, which are not all inclusive.

1. Delinquent Staffing Report. When the ICF/MR provider fails to timely submit a required, completed staffing report. After DHH notifies the provider of the delinquent report, vendor payment may be withheld until the completed report is received.

2. Unapproved Staffing Shortage. When a staffing report indicates an unapproved staffing shortage, vendor payment may be withheld until staffing is brought into compliance.

3. Incorrect/Inappropriate Charges. When DHH determines that the ICF/MR provider has incorrectly or inappropriately charged clients, families, or responsible parties, or there has been misapplication of client funds, vendor payment may be withheld until the provider does the following:

a. makes restitution; and

b. submits documentation of such restitution to BHSF's Institutional Reimbursement Section.

4. Delinquent Cost Report. When an ICF/MR provider fails to submit a cost report within 90 days from the fiscal year end closing date, a penalty of 5 percent of the total

monthly payment for the first month and a progressive penalty of 5 percent of the total monthly payment for each succeeding month may be levied and withheld from the vendor's payment for each month that the cost report is due, not extended, and not received. The penalty is nonrefundable.

NOTE: DHH's Institutional Reimbursement Section may grant a 30-day extension of the 90-day time limit, when requested by the ICF/MR provider, if just cause has been established. Extensions beyond 30 days may be approved for situations beyond the ICF/MR provider's control.

5. Cost Reports Errors. Cost reports errors greater than 10 percent in the aggregate for the ICF/MR provider for the cost report year may result in a maximum penalty of 10 percent of the current per diem rate for each month the cost report errors are not correct. The penalty is nonrefundable.

6. Corrective Action for Audit Findings. Vendor payments may be withheld when an ICF/MR facility fails to submit corrective action in response to financial and compliance audit findings within 15 days after receiving the notification letter until such time compliance is achieved.

7. Failure to Respond or Adequately Respond to Requests for Financial/Statistical Information. When an ICF/MR facility fails to respond or adequately respond to requests from DHH for financial and statistical information within 15 days after receiving the notification letter, vendor payments may be withheld until such time the requested information is received.

8. Insufficient Medical Recertification. When an ICF/MR provider fails to secure recertification of a client's need for care and services, the vendor's payment for that individual may be withheld or recouped until compliance is achieved.

9. Inadequate Review/Revision of Plan of Care (IHP). When an ICF/MR provider repeatedly fails to ensure that an adequate plan of care for a client is reviewed and revised at least at required intervals, the vendor's payment may be withheld or recouped until compliance is achieved.

10. Failure to Submit Response to Survey Reports. When an ICF/MR provider fails to submit an acceptable response within 30 days after receiving a survey report from DHH, HCFA, OIG and the legislative auditor, vendor payments may be withheld until an adequate response is received, unless the appropriate agency extends the time limit.

11. Corrective Action on Complaints. When an ICF/MR fails to submit an adequate corrective action plan in response to a complaint within seven days after receiving the complaint report, vendor payments may be withheld until an adequate corrective action plan is received, unless the time limit is extended by the DHH.

12. Delinquent Utilization Data Requests. Facilities will be required to timely submit utilization data requested by the DHH. Providers will be given written notice when such utilization data has not been received by the due date. Such notice will advise the provider of the date the utilization data must be received by to avoid withholding of vendor payments. The due date will never be less than 10 days from the date the notice is mailed to the provider. If the utilization data is not received by the due date provided in the notice, the medical vendor's payment will be withheld until the utilization data is received.

13. Termination or Withdrawal from the Medicaid Program. When a provider is terminated or withdraws from the Medicaid Program, vendor payment will be withheld until all programmatic and financial issues are resolved.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:701 (April 1999), repromulgated LR 31:2247 (September 2005).

§32309. Civil Fines

A. Louisiana R.S. 40:2199 authorized DHH to impose monetary sanctions on those health care facilities found to be out of compliance with any state or federal law or rule concerning the operation and services of the health care provider.

1. Any ICF/MR found to be in violation of any state or federal statute, regulation, or any Department of Health and Hospitals (DHH) rule adopted pursuant to the Act governing the administration and operation of the facility may be sanctioned as provided in the schedule of fines listed under Paragraph 2 below.

a. A *repeat violation* is defined as a violation of a similar nature as a previously cited violation that occurs within 18 months of the previously cited violation. DHH has the authority to determine when a violation is a *repeat violation.*

b. The opening or operation of a facility without a license or registration will be a misdemeanor, punishable upon conviction by a fine of not less than $1,000 nor more than $5,000.

i. Each day's violations will constitute a separate offense.

ii. On learning of such an operation, DHH will refer the facility to the appropriate authorities for prosecution.

c. Any ICF/MR found to have a violation that poses a threat to the health, safety, rights, or welfare of a resident or client may be liable for civil fines in addition to any criminal action that may be brought under other applicable laws.

B. Description of Violations and Applicable Civil Fines

1. Class A Violations

a. A Class A violation is a violation of a rule that creates a condition or occurrence relating to the maintenance or operation of a facility that results in death or serious harm

to a resident or client. Examples of Class A violations include, but are not limited to:

i. acts or omissions by an employee or employees of a facility that either knowingly or negligently resulted in the death of a resident or client; and

ii. acts or omissions by an employee or employees of a facility that either knowingly or negligently resulted in serious harm to a resident or client.

b. Civil fines for Class A violations may not exceed:

i. $2,500 for the first violation; or

ii. $5,000 per day for repeat violations.

2. Class B Violations

a. A Class B violation is a violation of a rule in which a condition or occurrence relating to the maintenance or operation of a facility is created that results in the substantial probability that death or serious harm to the client or resident will result if the condition or occurrence remains uncorrected. Examples of Class B violations include, but are not limited to, the following:

i. medications or treatments improperly administered or withheld;

ii. lack of functioning equipment necessary to care for clients;

iii. failure to maintain emergency equipment in working order;

iv. failure to employ a sufficient number of adequately trained staff to care for clients; and

v. failure to implement adequate infection control measures.

b. Civil fines for Class B violations may not exceed:

i. $1,500 for the first violation; or

ii. $3,000 per day for repeat violations.

3. Class C Violations

a. A Class C violation is a violation of a rule in which a condition or occurrence relating to the maintenance or operation of the facility is created that threatens the health, safety, or welfare of a client or resident. Examples of Class C violations include, but are not limited to, the following:

i. failure to perform treatments as ordered by the physician;

ii. improper storage of poisonous substances;

iii. failure to notify physician and family of changes in condition of the client or resident;

iv. failure to maintain equipment in working order;

v. inadequate supply of needed equipment;

vi. lack of adequately trained staff necessary to meet clients' needs; and

vii. failure to adhere to professional standards in giving care to the client.

b. Civil fines for Class C violations may not exceed:

i. $1,000 for the first violation;

ii. $2,000 per day for repeat violations.

4. Class D Violations

a. Class D violations are violations of rules related to administrative and reporting requirements that do not threaten the health, safety, rights, or welfare of a client or resident. Examples of Class D violations include, but are not limited to, the following:

i. failure to submit written reports of accidents;

ii. failure to timely submit a Plan of Correction;

iii. falsification of a record; and

iv. failure to maintain clients financial records as required by rules or regulations.

b. Civil fines for Class D violations may not exceed:

i. $100 for the first violation;

ii. $250 per day for repeat violations.

5. Class E Violations. Class E violations occur when a facility fails to submit a statistical or financial report in a timely manner when such a report is required by a rule.

a. Civil fines for Class E violations may not exceed:

i. $50 for the first violation;

ii. $100 per day for repeat violations.

C. Maximum Amount for a Civil Fine

1. The aggregate fines assessed for violations determined in any one month may not exceed $10,000 for a Class A and Class B violations.

2. The aggregate fines assessed Class C, Class D, and Class E violations determined in any one month may not exceed $5,000.

D. DHH will have the authority to determine whether a violation is a repeat violation and sanction the provider accordingly. Violations may be considered repeat violations by DHH when the following conditions exist:

1. when DHH has established the existence of a violation as of a particular date and the violation is one that may be reasonably expected to continue until corrective action is taken, DHH may elect to treat said continuing violation as a repeat violation subject to appropriate fines for each day following the date on which the initial violation is established, until such time as there is evidence that the violation has been corrected; or

2. when DHH has established the existence of a violation and another violation that is the same or substantially similar to the cited violation occurs within 18 months, the second and all similar subsequent violations occurring within the 18-month time period will be considered repeat violations and sanctioned accordingly.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:701 (April 1999), repromulgated LR 31:2248 (September 2005).

Chapter 325. Decertification

§32501. Termination of Certification

A. An ICF/MR may voluntarily or involuntarily lose its participating status in the Medical Assistance Program.

B. Reasons for Decertification of an ICF/MR

1. The ICF/MR may voluntarily withdraw from the program for reasons of its own. The owner and administrator will submit a written notice of withdrawal to the DHH's HSS at least 60 days in advance.

2. A new owner may decide against participation in the program. A written 60-day notice of withdrawal will be submitted to DHH's HSS.

3. DHH may decertify an ICF/MR for failure to comply with Title XIX standards, thus canceling the facility's provider agreement.

4. DHH may decertify an ICF/MR if deficiencies pose immediate jeopardy to the client's health, safety, rights, or welfare.

5. The ICF/MR may allow its provider agreement to expire. A written 60-day advance notice of withdrawal will be submitted to the DHH's HSS.

6. DHH may cancel the provider agreement if and when it is determined that the ICF/MR is in material breach of the contract.

C. Recertification of an Involuntarily Decertified ICF/MR. After involuntary decertification, an ICF/MR cannot participate as a medical assistance provider unless the following conditions are met:

1. the reasons for the decertification or nonrenewal of the contract no longer exist;

2. reasonable assurance exists that the factors causing the decertification will not recur;

3. the ICF/MR demonstrates compliance with the required standards for a 60-day period prior to reinstatement in a participating status; and

4. a professional medical review reports that clients are receiving proper care and services.

D. Denial of Payments for New Admissions

1. New Admissions. New admissions refer to the admission of a person who has never been a Title XIX client in the ICF/MR or, if previously admitted, had been discharged or had voluntarily left the ICF/MR. This term does not include the following:

a. individuals who were in the ICF/MR before the effective date of denial of payment for new admissions, even if they become eligible for Title XIX after that date;

b. individuals who, after a temporary absence from the ICF/MR, are readmitted to beds reserved for them in accordance with the admission process.

2. Basis for Denial of Payment. DHH may deny payment for new admissions to an ICF/MR that no longer meets applicable requirements as specified in these standards.

a. ICF/MR's deficiencies do not pose immediate jeopardy (serious threat). If DHH finds that the ICF/MR's deficiencies do not pose immediate jeopardy to clients' health, safety, rights, or welfare, DHH may either terminate the ICF/MRs provider agreement or deny payment for new admissions.

b. ICF/MR's deficiencies do pose immediate jeopardy (serious threat). If DHH finds that the ICF/MR's deficiencies do pose immediate jeopardy to clients' health, safety, rights, or welfare, and thereby terminates the ICF/MR's provider agreement, DHH may additionally seek to impose the denial of payment for new admissions.

3. DHH Procedures. Before denying payments for new admissions, DHH will be responsible for the following:

a. providing the ICF/MR a time frame of up to 60 days to correct the cited deficiencies and comply with the standards for ICF/MRs;

b. giving the ICF/MR notice of the intent to deny payment for new admissions and an opportunity to request an Informal Reconsideration if the facility has not achieved compliance at the end of the 60-day period;

c. providing an informal hearing if requested by the ICF/MR that included the following:

i. giving the ICF/MR the opportunity to present before a state Medicaid official not involved in the initial determination, evidence or documentation, in writing or in person, to refute the decision that the ICF/MR is out of compliance with the applicable standards for participation; and

ii. submitting a written decision setting forth the factual and legal basis pertinent to a resolution of the dispute.

d. providing the facility and the public at least 15 days advance notice of the effective date of the sanction and reasons for the denial of payments for new admissions should the informal hearing decision be adverse to the ICF/MR.

4. Duration of Denial of Payments and Subsequent Termination

a. Period of Denial. The denial of payments for new admissions will continue for 11 months after the month it was imposed unless, before the end of that period, DHH determines:

i. the ICF/MR has corrected the deficiencies or is making a good faith effort to achieve compliance with the standards for ICF/MR participation; or

ii. the deficiencies are such that it is now necessary to terminate the ICF/MR's provider agreement.

b. Subsequent Termination. DHH must terminate an ICF/MR's provider agreement under the following conditions:

i. upon finding that the ICF/MR has been unable to achieve compliance with the standards for participation during the period that payments for new admissions had been denied;

ii. effective the day following the last day of the denial of payments;

iii. in accordance with the procedures for appeal of termination set forth in Chapter 321, Appeals.

E. Examples of Situations Determined to Pose Immediate Jeopardy (Serious Threat). Listed below are some examples of situations determined to pose immediate jeopardy (serious threat) to the health, safety, rights, and welfare of clients in ICF/MR. These examples are not intended to be all inclusive. Other situations adversely affecting clients could constitute sufficient basis for the imposition of sanctions.

1. Poisonous Substances. An ICF/MR fails to provide proper storage of poisonous substances, and this failure results in death of or serious injury to a client or directly threatens the health, safety, or welfare of a client.

2. Falls. An ICF/MR fails to maintain required direct care staffing and/or a safe environment as set forth in the regulations, and this failure directly causes a client to fall resulting in death or serious injury or directly threatens the health, safety, or welfare of a client. Examples:

a. equipment not properly maintained; or

b. personnel not responding to a client's request for assistance.

3. Assaults

a. By Other Clients. An ICF/MR fails to maintain required direct care staffing and fails to take measures when it is known that a client is combative and assaultive with other clients, and this failure causes an assault upon another client, resulting in death or serious injury or directly threatens the health, safety, and welfare of another client.

b. By Staff. An ICF/MR fails to take corrective action (termination, legal action) against an employee who has a history of client abuse and assaults a client causing death or the situation directly threatens the health, safety, and welfare of a client.

4. Physical Restraints Resulting in Permanent Injury. ICF/MR personnel improperly apply physical restraints contrary to published regulations or fail to check and release restraints as directed by regulations or physician's written instructions, and such failure results in permanent injury to a client's extremity or death or directly threatens the health, safety and welfare of a client.

5. Control of Infections. An ICF/MR fails to follow or meet infection control standards as ordered in writing by the physician, and this failure results in infections leading to the death of or serious injury to a client or directly threatens the health, safety, and welfare of a client.

6. Medical Care

a. An ICF/MR fails to secure proper medical assistance for a client, and this failure results in the death of or serious injury to the client.

b. A client's condition declined and no physician was informed, and this failure directly threatens the health, safety, or welfare of the client. This would also include the following:

i. failure to follow up on unusual occurrences of negative findings;

ii. failure to obtain information regarding appropriate care before and after a client's hospitalization;

iii. failure to timely hospitalize a client during a serious illness.

c. ICF/MR personnel have not followed written physician's orders, and this failure directly threatens the health, safety, or welfare of a client. This includes failure to fill prescriptions timely.

7. Natural Disaster/Fire. An ICF/MR fails to train its staff members in disaster/fire procedures as required by state rules for licensing of ICF/MRs or an ICF/MR fails to meet staffing requirements, and such failures result in the death of or serious injury to a client during natural disaster, fire or directly threatens the health, safety, or welfare of a client.

8. Decubitus Ulcers (Bed Sores). An ICF/MR fails to follow decubitus ulcer care measures in accordance with a physician's written orders, and such failure results in the death of, serious injury to, or discomfort of the client or directly threatens the health, safety, and welfare of a client.

9. Elopement. An ICF/MR fails to provide necessary supervision of its clients or take measures to prevent a client with a history of elopement problems from wandering away and such failure results in the death of or serious harm to the client or directly threatens the health, safety, and welfare of the client. Examples of preventive measures include, but are not limited to:

a. documentation that the elopement problem has been discussed with the client's family and the Interdisciplinary Team; and

b. that personnel have been trained to make additional efforts to monitor these clients.

10. Medications

a. An ICF/MR knowingly withholds a client's medications and such actions results in the death of or serious harm to the client or directly threatens the health, safety, and welfare of the client.

NOTE: The client does have the right to refuse medications. Such refusal must be documented in the client's record and brought to the attention of the physician and ID team.

b. medication omitted without justification;

c. excessive medication errors;

d. improper storage of narcotics or other prescribed drugs, mishandling of drugs or other pharmaceutical problems.

11. Environment/Temperature. An ICF/MR fails to reasonably maintain its heating and air-conditioning system as required by regulations, and this failure results in the death of, serious harm to, or discomfort of a client or creates the possibility of death or serious injury. Isolated incidents of breakdown or power failure will not be considered immediate jeopardy.

12. Improper Treatments

a. ICF/MR personnel knowingly perform treatment contrary to a physician's order, and such treatment results in the death of or serious injury to the client or directly threatens the health, safety, and welfare of the client.

b. An ICF/MR fails to feed clients who are unable to feed themselves as set forth in physician's instructions.

NOTE: Meals should be served at the required temperature.

c. An ICF/MR fails to obtain a physician's order for use of chemical or physical restraints; the improper application of a physical restraint; or failure of facility personnel to check and release the restraints periodically as specified in state regulations.

13. Life Safety. An ICF/MR knowingly fails to maintain the required Life Safety Code System such as:

a. properly functioning sprinklers, fire alarms, smoke sensors, fire doors, electrical wiring;

b. the practice of fire or emergency evacuation plans; or

c. stairways, hallways and exits free from obstruction; and noncompliance with these requirements results in the death of or serious injury to a client or directly threatens the health, safety, and welfare of a client.

14. Staffing. An ICF/MR consistently fails to maintain minimum staffing that directly threatens the health, safety, or welfare of a client. Isolated incidents where the facility does not maintain staffing due to personnel calling in sick or other emergencies are excluded.

15. Dietary Services. An ICF/MR fails to follow the minimum dietary needs or special dietary needs as ordered by a physician, and failure to meet these dietary needs threatens the health, safety or welfare of a client. The special diets must be prepared in accordance with physician's orders or a diet manual approved by the American Dietary Association.

16. Sanitation. An ICF/MR fails to maintain state and federal sanitation regulations, and those violations directly affect and threaten the health, safety, or welfare of a client. Examples are:

a. strong odors linked to a lack of cleanliness;

b. dirty buildup on floors and walls;

c. dirty utensils, glasses and flatware;

d. insect or rodent infestation.

17. Equipment and Supplies. An ICF/MR fails to provide equipment and supplies authorized in writing by a physician as necessary for a client's care, and this failure directly threatens the health, safety, welfare or comfort of a client.

18. Client Rights

a. An ICF/MR violates its clients' rights and such violations result in the clients' distress to such an extent that their psychosocial functions are impaired or such violations directly threaten their psychosocial functioning. This includes psychological abuse.

b. The ICF/MR permits the use of corporal punishment.

c. The ICF/MR allows the following responses to clients by staff members and employment supervisors:

i. physical exercise or repeated physical motions;

ii. excessive denial of usual services;

iii. any type of physical hitting or other painful physical contacts except as required by medical, dental, or first aid procedures necessary to preserve the individual's life or health;

iv. requiring the individual to take on an extremely uncomfortable position;

v. verbal abuse, ridicule, or humiliation;

vi. requiring the individual to remain silent for a long period of time;

vii. denial of shelter, warmth, clothing or bedding; or

viii. assignment of harsh physical work.

d. The ICF/MR fails to afford the client with the opportunity to attend religious services.

e. The ICF/MR denies the client the right to bring his or her personal belongings to the program, to have

access, and to acquire belongings in accordance with the service plan.

f. The ICF/MR denies a client a meal without a doctor's order.

g. The ICF/MR does not afford the client with suitable supervised opportunities for interaction with members of the opposite sex, except where a qualified professional responsible for the formulation of a particular individual's treatment/habilitation plan writes an order to the contrary and explains the reasons.

NOTE: The secretary of DHH has the final authority to determine what constitutes "immediate jeopardy" or serious threat.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 442.12-442.117.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:701 (April 1999), repromulgated LR 31:2249 (September 2005).

Chapter 327. Emergency Awareness

§32701. Disaster Preparedness

A. Written Plans. ICFs/MR shall have written procedures complete with instructions to be followed in the event of an internal or external disaster such as fire or other emergency actions, including:

1. specifications of evacuation routes and procedures;

2. instructions for the care of injuries and/or casualties (client and personnel) arising from such disaster;

3. procedures for the prompt transfer of records;

4. instructions regarding methods of containing fire; and

5. procedures for notification of appropriate persons.

B. Employee Training. All ICF/MR employees shall be trained in disaster preparedness as part of employment orientation. The disaster preparedness training shall include orientation, ongoing training, and drills for all personnel. The purpose shall be that each employee promptly and correctly carry out his/her specific role in the event of a disaster. The facility shall periodically rehearse these procedures for disaster preparedness. The minimum requirements shall be drills once each quarter for each shift.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1702 (August 2004), repromulgated LR 31:2252 (September 2005).

Chapter 329. Reimbursement Methodology

Subchapter A. Non-State Facilities

§32901. Cost Reports

A. Intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) are required to file annual cost reports to the bureau in accordance with the following instructions.

1. Each ICF/IID is required to report all reasonable and allowable costs on a regular facility cost report, including any supplemental schedules designated by the bureau.

2. Separate cost reports must be submitted by central/home offices and habilitation programs when costs of those entities are reported on the facility cost report.

B. Cost reports must be prepared in accordance with cost reporting instructions adopted by the bureau using definitions of allowable and nonallowable cost contained in the Medicare provider reimbursement manual unless other definitions of allowable and nonallowable cost are adopted by the bureau.

1. Each provider shall submit an annual cost report for fiscal year ending June 30. The cost reports shall be filed within 90 days after the state's fiscal year ends.

2. Exceptions. Limited exceptions for extensions to the cost report filing requirements will be considered on an individual facility basis upon written request by the provider to the Medicaid director or designee. Providers must attach a statement describing fully the nature of the exception request. The extension must be requested by the normal due date of the cost report.

C. Direct Care Floor

1. A facility wide direct care floor may be enforced upon deficiencies related to direct care staffing requirements noted during the HSS annual review or during a complaint investigation in accordance with LAC 50:I.5501 et seq.

2. For providers receiving pervasive plus supplements in accordance with §32903.H or other client specific adjustments to the rate in accordance with §32903.I, the facility wide direct care floor is established at 94 percent of the per diem direct care payment and at 100 percent of any rate supplements or add-on payments received by the provider, including the pervasive plus supplement, the complex care add-on payment and other client specific adjustments to the rate. The direct care floor will be applied to the cost reporting year in which the facility receives a pervasive plus supplement and/or a client specific rate adjustment. In no case, however, shall a facility receiving a pervasive plus supplement and/or client specific rate adjustment have total facility payments reduced to less than 104 percent of the total facility cost as a result of imposition of the direct care floor.

3. For providers receiving complex care add-on payment in accordance with §32915, but not receiving pervasive plus supplements in accordance with §32903.H or other client specific adjustments to the rate in accordance with §32903.I, the facility wide direct care floor is established at 85 percent of the per diem direct care payment and at 100 percent of the complex care add-on payment. The direct care floor will be applied to the cost reporting year in which the facility receives a complex care add-on payment. In no case shall a facility receiving a complex care add-on payment have total facility payments reduced to less than 104 percent of the total facility cost as a result of imposition of the direct care floor.

4. For facilities for which the direct care floor applies, if the direct care cost the facility incurred on a per diem basis is less than the appropriate facility direct care floor, the facility shall remit to the bureau the difference between these two amounts times the number of facility Medicaid days paid during the cost reporting period. This remittance shall be payable to the bureau upon submission of the cost report.

5. Upon completion of desk reviews or audits, facilities will be notified by the bureau of any changes in amounts due based on audit or desk review adjustments.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:1592 (July 2005), repromulgated LR 31:2252 (September 2005), amended LR 33:461 (March 2007), amended LR 44:1446 (August 2018).

§32903. Rate Determination

A. Resident per diem rates are calculated based on information reported on the cost report. ICFs-MR will receive a rate for each resident. The rates are based on cost components appropriate for an economic and efficient ICF-MR providing quality service. The resident per diem rates represent the best judgment of the state to provide reasonable and adequate reimbursement required to cover the costs of economic and efficient ICFs-MR.

B. The cost data used in setting base rates will be from the latest available audited or desk reviewed cost reports. The initial rates will be adjusted to maintain budget neutrality upon transition to the ICAP reimbursement methodology. For rate periods between rebasing, the rates will be trended forward using the index factor contingent upon appropriation by the legislature.

C. For dates of service on or after August 1, 2005, a resident's per diem rate will be the sum of:

1. direct care per diem rate;
2. care related per diem rate;
3. administrative and operating per diem rate;
4. capital rate; and
5. provider fee.

D. Determination of Rate Components

1. The direct care per diem rate shall be a set percentage over the median adjusted for the acuity of the resident based on the ICAP, tier based on peer group. The direct care per diem rate shall be determined as follows.

a. Median Cost. The direct care per diem median cost for each ICF-MR is determined by dividing the facility's total direct care costs reported on the cost report by the facility's total days during the cost reporting period. Direct care costs for providers in each peer group are arrayed from low to high and the median (50^{th} percentile) cost is determined for each peer group.

b. Median Adjustment. The direct care component shall be adjusted to 105 percent of the direct care per diem median cost in order to achieve reasonable access to care.

c. Inflationary Factor. These costs shall be trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor.

d. Acuity Factor. Each of the ICAP levels will have a corresponding acuity factor. The median cost by peer group, after adjustments, shall be further adjusted by the acuity factor (or multiplier) as follows.

ICAP Support Level	Acuity Factor (Multiplier)
Pervasive	1.35
Extensive	1.17
Limited	1.00
Intermittent	.90

e. Direct Service Provider Wage Enhancement. For dates of service on or after February 9, 2007, the direct care reimbursement in the amount of $2 per hour to ICF-MR providers shall include a direct care service worker wage enhancement incentive. It is the intent that this wage enhancement be paid to the direct care staff. Non compliance with the wage enhancement shall be subject to recoupment.

i. At least 75 percent of the wage enhancement shall be paid to the direct support professional and 25 percent shall be used to pay employer-related taxes, insurance and employee benefits.

ii. The wage enhancement will be added on to the current ICAP rate methodology as follows:

(a). Per diem rates for recipients residing in 1-8 bed facilities will increase $16.00;

(b). Per diem rates for recipients residing in 9-16 bed facilities will increase $14.93; and

(c). Per diem rates for recipients residing in 16+ bed facilities will increase $8.

2. The care related per diem rate shall be a statewide price at a set percentage over the median and shall be determined as follows.

a. Median Cost. The care related per diem median cost for each ICF-MR is determined by dividing the facility's total care related costs reported on the cost report by the facility's actual total resident days during the cost

reporting period. Care related costs for all providers are arrayed from low to high and the median (50th percentile) cost is determined.

b. Median Adjustment. The care related component shall be adjusted to 105 percent of the care related per diem median cost in order to achieve reasonable access to care.

c. Inflationary Factor. These costs shall be trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor.

3. The administrative and operating per diem rate shall be a statewide price at a set percentage over the median, tier based on peer group. The administrative and operating component shall be determined as follows.

a. Median Cost. The administrative and operating per diem median cost for each ICF-MR is determined by dividing the facility's total administrative and operating costs reported on the cost report by the facility's actual total resident days during the cost reporting period. Administrative and operating costs for all providers are arrayed from low to high and the median (50th percentile) cost is determined.

b. Median Adjustment. The administrative and operating component shall be adjusted to 103 percent of the administrative and operating per diem median cost in order to achieve reasonable access to care.

c. Inflationary Factor. These costs shall be trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor.

4. The capital per diem rate shall be a statewide price at a set percentage over the median, tier based on peer group. The capital per diem rate shall be determined as follows.

a. Median Cost. The capital per diem median cost for each ICF-MR is determined by dividing the facility's total capital costs reported on the cost report by the facility's actual total resident days during the cost reporting period. Capital costs for providers of each peer group are arrayed from low to high and the median (50^{th} percentile) cost is determined for each peer group.

b. Median Adjustment. The capital cost component shall be adjusted to 103 percent of the capital per diem median cost in order to achieve reasonable access to care.

c. Inflationary Factor. Capital costs shall not be trended forward.

d. The provider fee shall be calculated by the department in accordance with state and federal rules.

i. Effective for dates of service on or after April 1, 2014, the add-on amount to each ICF/ID's per diem rate for the provider fee shall be increased to $16.15 per day.

E. The rates for the 1-8 bed peer group shall be set based on costs in accordance with §32903.B–D.4.d. The reimbursement rates for peer groups of larger facilities will also be set in accordance with §32903.B–D.4.d; however, the rates will be limited as follows.

1. The 9-15 peer group reimbursement rates will be limited to 95 percent of the 1-8 bed peer group reimbursement rates.

2. The 16-32 bed peer group reimbursement rates will be limited to 95 percent of the 9-15 bed peer group reimbursement rates.

3. The 33 and greater bed peer group reimbursement rates will be set in accordance with §32903.B–D.4.d, limited to 95 percent of the 16-32 bed peer group reimbursement rates.

F. Rebasing of rates will occur at least every three years utilizing the most recent audited and/or desk reviewed cost reports.

G. Adjustments to the Medicaid daily rate may be made when changes occur that eventually will be recognized in updated cost report data (such as a change in the minimum wage or FICA rates). These adjustments would be effective until such time as the data base used to calculate rates fully reflect the change. Adjustments to rates may also be made when legislative appropriations would increase or decrease the rates calculated in accordance with this rule. The secretary of the Department of Health and Hospitals makes the final determination as to the amount and when adjustments to rates are warranted.

H. A facility requesting a pervasive plus rate supplement shall bear the burden of proof in establishing the facts and circumstances necessary to support the supplement in a format and with supporting documentation specified by the DHH ICAP Review Committee.

1. The DHH ICAP Review Committee shall make a determination of the most appropriate staff required to provide requested supplemental services.

2. The amount of the Pervasive Plus supplement shall be calculated using the Louisiana Civil Service pay grid for the appropriate position as determined by the DHH ICAP Review Committee and shall be the 25^{th} percentile salary level plus 20 percent for related benefits times the number of hours approved.

I. Other Client Specific Adjustments to the Rate. A facility may request a client specific rate supplement for reimbursement of the costs for enteral nutrition, ostomy or tracheotomy medical supplies or a vagus nerve stimulator.

1. The provider must submit sufficient medical supportive documentation to the DHH ICAP Review Committee to establish medical need for enteral nutrition, ostomy or tracheotomy medical supplies.

a. The amount of reimbursement determined by the ICAP Review Committee shall be based on the average daily cost for the provision of the medical supplies.

b. The provider must submit annual documentation to support the need for the adjustment to the rate.

2. Prior authorization for implementation for the Vagus nerve stimulator shall be requested after the evaluation has been completed but prior to stimulator

implantation. The request to initiate implantation shall come from the multi-disciplinary team as a packet with the team's written decision regarding the recipient's candidacy for the implant and the results of all pre-operative testing. The PA-01 form for the device and surgeon shall be included in the packet forwarded to Unisys.

a. The amount of reimbursement shall be the established fee on the Medicaid Fee Schedule for medical equipment and supplies.

J. Effective for dates of service on or after September 1, 2009, the reimbursement rate for non-state intermediate care facilities for persons with developmental disabilities shall be increased by 1.59 percent of the per diem rate on file as of August 31, 2009.

K. Effective for dates of service on or after August 1, 2010, the per diem rates for non-state intermediate care facilities for persons with developmental disabilities (ICFs/DD) shall be reduced by 2 percent of the per diem rates on file as of July 31, 2010.

1. Effective for dates of service on or after December 20, 2010, non-state ICFs/DD which have downsized from over 100 beds to less than 35 beds prior to December 31, 2010 shall be excluded from the August 1, 2010 rate reduction.

L. Effective for dates of service on or after August 1, 2010, the per diem rates for ICFs/DD which have downsized from over 100 beds to less than 35 beds prior to December 31, 2010 shall be restored to the rates in effect on January 1, 2009.

M. Effective for dates of service on or after July 1, 2012, the per diem rates for non-state intermediate care facilities for persons with developmental disabilities (ICFs/DD) shall be reduced by 1.5 percent of the per diem rates on file as of June 30, 2012.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:2253 (September 2005), amended LR 33:462 (March 2007), LR 33:2202 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1555 (July 2010), LR 37:3028 (October 2011), LR 39:1780 (July 2013), LR 39:2766 (October 2013), LR 41:539 (March 2015).

§32905. ICAP Requirements

A. An ICAP must be completed for each recipient of ICF-MR services upon admission and while residing in an ICF-MR in accordance with departmental regulations.

B. Providers must keep a copy of the recipient's current ICAP protocol and computer scored summary sheets in the recipient's file. If a recipient has changed ICAP service level, providers must also keep a copy of the recipient's ICAP protocol and computer scored summary sheets supporting the prior level.

C. ICAPs must reflect the resident's current level of care.

D. Providers must submit a new ICAP to the Regional Health Standards office when the resident's condition reflects a change in the ICAP level that indicates a change in reimbursement.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:1593 (July 2005), repromulgated LR 31:2254 (September 2005).

§32907. ICAP Monitoring

A. ICAP scores and assessments will be subject to review by DHH and its contracted agents. The reviews of ICAP submissions include, but are not limited to:

1. reviews when statistically significant changes occur within an ICAP submission or submissions;

2. random selections of ICAP submissions;

3. desk reviews of a sample of ICAP submissions; and

4. on-site field reviews of ICAPs.

B. ICAP Review Committee

1. Requests for Pervasive Plus must be reviewed and approved by the DHH ICAP Review Committee.

2. The ICAP Review Committee shall represent DHH should a provider request an informal reconsideration regarding the Regional Health Standards' determination.

3. The ICAP Review Committee shall make final determination on any ICAP level of care changes prior to the appeals process.

4. The ICAP Review Committee shall be made up of the following:

a. the director of the Health Standards Section or his/her appointee;

b. the director of Rate and Audit Review Section or his/her appointee;

c. the assistant secretary for the Office for Citizens with Developmental Disabilities or his/her appointee;

d. other persons as appointed by the secretary.

C. When an ICAP score is determined to be inaccurate, the department shall notify the provider and request documentation to support the level of care. If the additional information does not support the level of care, an ICAP rate adjustment will be made to the appropriate ICAP level effective the first day of the month following the determination.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:1594 (July 2005), repromulgated LR 31:2254 (September 2005).

§32909. Audits

A. Each ICF-MR shall file an annual facility cost report and a central office cost report.

B. ICF-MR 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 for the department shall be at the discretion of DHH.

1. A representative sample of the ICF-MR shall be fully audited to ensure the fiscal integrity of the program and compliance of providers with program regulations governing reimbursement.

2. Limited scope and exception audits shall also be conducted as determined by DHH.

3. DHH conducts desk reviews of all the cost reports received. DHH also conducts on-site audits of provider records and cost reports.

a. DHH seeks to maximize the number of on-site audited cost reports available for use in its cost projections although the number of on-site audits performed each year may vary.

b. Whenever possible, the records necessary to verify information submitted to DHH on Medicaid cost reports, including related-party transactions and other business activities engaged in by the provider, must be accessible to DHH audit staff in the state of Louisiana.

D. Cost of Out-of-State Audits

1. When records are not available to DHH audit staff within Louisiana, the provider must pay the actual costs for DHH staff to travel and review the records out-of-state.

2. If a provider fails to reimburse DHH for these costs within 60 days of the request for payment, DHH may place a hold on the vendor payments until the costs are paid in full.

E. In addition to the exclusions and adjustments made during desk reviews and on-site audits, DHH 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.

F. The facility shall retain such records or files as required by DHH 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.

G. If DHH's auditors determine that a facility's records are unauditable, the vendor payments may be withheld until the facility submits an acceptable plan of correction to reconstruct the records. Any additional costs incurred to complete the audit shall be paid by the provider.

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

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

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

I. If DHH's audit of the residents= personal funds account indicate a material number of transactions were not sufficiently supported or material noncompliance, then DHH shall initiate a full scope audit of the account. The cost of the full scope audit shall be withheld from the vendor payments.

J. The ICF-MR 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 facility records and cost report preparation available during the audit;

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

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

6. correcting areas of noncompliance with state and federal regulations immediately after the exit conference time limit of 15 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 the Secretary, Bureau of Health Services Financing, LR 31:1594 (July 2005), repromulgated LR 31:2254 (September 2005).

§32911. Exclusions from Database

A. Providers with disclaimed audits and providers with cost reports for other than a 12-month period will be excluded from the database used to calculate the rates.

B. Providers who do not submit ICAP scores will be paid at the Intermittent level until receipt of ICAP scores.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:1594 (July 2005), repromulgated LR 31:2255 (September 2005).

§32913. Leave of Absence Days

A. The reimbursement to non-state ICF/DDs for hospital leave of absence days is 75 percent of the applicable per diem rate.

B. The reimbursement for leave of absence days is 100 percent of the applicable per diem rate.

1. A leave of absence is a temporary stay outside of the ICF/DD, for reasons other than for hospitalization,

provided for in the recipient's written individual habilitation plan.

C. Effective for dates of service on or after February 20, 2009, the reimbursement to non-state ICF/DDs for leave of absence days is 75 percent of the applicable per diem rate on file as of February 19, 2009.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 27:57 (January 2001), repromulgated LR 31:2255 (September 2005), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1897 (September 2009).

§32915. Complex Care Reimbursements

A. Private (non-state) intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) may receive an add-on payment to the per diem rate for providing complex care to Medicaid recipients who require such services. The add-on rate adjustment shall be a flat fee amount and may consist of payment for any one of the following components:

1. equipment only;
2. direct service worker (DSW);
3. nursing only;
4. equipment and DSW;
5. DSW and nursing;
6. nursing and equipment; or
7. DSW, nursing, and equipment.

B. Private (non-state) owned ICFs/IID may qualify for an add-on rate for recipients meeting documented major medical or behavioral complex care criteria. This must be documented on the complex support need screening tool provided by the department. All medical documentation indicated by the screening tool form and any additional documentation requested by the department must be provided to qualify for the add-on payment.

C. The complex support need screening tool shall be completed and submitted to the department annually from the date of initial approval of each add-on payment. This annual submittal shall be accompanied by all medical documentation indicated by the screening tool form and any additional documentation requested by the department.

D. In order to meet the complex care criteria, the presence of a significant medical or behavioral health need must exist and be documented. This must include:

1. endorsement of at least one qualifying condition with supporting documentation; and

2. endorsement of symptom severity in the appropriate category based on qualifying condition(s) with supporting documentation.

a. Qualifying conditions for complex care must include at least one of the following as documented on the complex support need screening tool:

i. significant physical and nutritional needs requiring full assistance with nutrition, mobility, and activities of daily living;

ii. complex medical needs/medically fragile; or

iii. complex behavioral/mental health needs.

E. Enhanced Supports. Enhanced supports must be provided and verified with supporting documentation to qualify for the add-on payment. This includes:

1. endorsement and supporting documentation indicating the need for additional direct service worker resources;

2. endorsement and supporting documentation indicating the need for additional nursing resources; or

3. endorsement and supporting documentation indicating the need for enhanced equipment resources (beyond basic equipment such as wheelchairs and grab bars).

F. One of the following admission requirements must be met in order to qualify for the add-on payment:

1. the recipient has been admitted to the facility for more than 30 days with supporting documentation of necessity and provision of enhanced supports; or

2. the recipient is transitioning from another similar agency with supporting documentation of necessity and provision of enhanced supports.

G. Qualification for a complex care add-on payment may be reviewed and re-determined by the department annually from the date of initial approval of each add-on payment. This review shall be performed in the same manner and using the same standard as the initial qualifying review under this section.

H. The department may require compliance with all applicable laws, rules, and regulations as a condition of an ICF/IID's qualification for the complex care add-on rate and may evaluate such compliance in its initial and annual qualifying reviews.

I. All of the following criteria will apply for continued evaluation and payment for complex care.

1. Recipients receiving enhanced rates will be included in annual surveys to ensure continuation of supports and review of individual outcomes.

2. Fiscal analysis and reporting will be required annually.

3. The provider will be required to report on the following outcomes:

a. hospital admissions and diagnosis/reasons for admission;

b. emergency room visits and diagnosis/reasons for admission;

c. major injuries;

d. falls; and

e. behavioral incidents.

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, LR 42:276 (February 2016), amended LR 44:1447 (August 2018), LR 45:273 (February 2019).

Subchapter C. Public Facilities

§32965. State-Owned and Operated Facilities

A. Medicaid payments to state-owned and operated intermediate care facilities for persons with developmental disabilities are based on the Medicare formula for determining the routine service cost limits as follows:

1. calculate each state-owned and operated ICF/DD's per diem routine costs in a base year;

2. calculate 112 percent of the average per diem routine costs; and

3. inflate 112 percent of the per diem routine costs using the skilled nursing facility (SNF) market basket index of inflation.

B. Each state-owned and operated facility's capital and ancillary costs will be paid by Medicaid on a "pass-through" basis.

C. The sum of the calculations for routine service costs and the capital and ancillary costs "pass-through" shall be the per diem rate for each state-owned and operated ICF/DD. The base year cost reports to be used for the initial calculations shall be the cost reports for the fiscal year ended June 30, 2002.

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, LR 39:325 (February 2013).

§32967. Quasi-Public Facilities

A. Medicaid payment to quasi-public facilities is a facility-specific prospective rate based on budgeted costs. Providers shall be required to submit a projected budget for the state fiscal year beginning July 1.

B. The payment rates for quasi-public facilities shall be determined as follows:

1. determine each ICF/DD's per diem for the base year beginning July 1;

2. calculate the inflation factor using an average CPI index applied to each facility's per diem for the base year to determine the inflated per diem;

3. calculate the median per diem for the facilities' base year;

4. calculate the facility's routine cost per diem for the SFY beginning July 1 by using the lowest of the budgeted, inflated or median per diem rates plus any additional allowances; and

5. calculate the final approved per diem rate for each facility by adding routine costs plus any "pass through" amounts for ancillary services, provider fees, and grant expenses.

C. Providers may request a final rate adjustment subject to submission of supportive documentation and approval by the department.

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, LR 39:326 (February 2013).

§32969. Transitional Rates for Public Facilities

A. Effective October 1, 2012, the department shall establish a transitional Medicaid reimbursement rate of $302.08 per day per individual for a public ICF/ID facility over 50 beds that is transitioning to a private provider, as long as the provider meets the following criteria:

1. shall have a fully executed cooperative endeavor agreement (CEA) with the Office for Citizens with Developmental Disabilities (OCDD) for the private operation of the facility;

2. shall have a high concentration of medically fragile individuals being served, as determined by the department;

a. for purposes of these provisions, a medically fragile individual shall refer to an individual who has a medically complex condition characterized by multiple, significant medical problems that require extended care;

3. incurs or will incur higher existing costs not currently captured in the private ICF/ID rate methodology; and

4. shall agree to downsizing and implement a pre-approved OCDD plan:

a. any ICF/ID home that is a cooperative endeavor agreement (CEA) to which individuals transition to satisfy downsizing requirements, shall not exceed 6-8 beds.

B. The transitional Medicaid reimbursement rate shall only be for the period of transition, which is defined as the term of the CEA or a period of four years, whichever is shorter.

1. The department may extend the period of transition up to September 30, 2020, if deemed necessary, for an active CEA facility that is:

a. a large facility of 100 beds or more;

b. serves a medically fragile population; and

c. provides continuous (24-hour) nursing coverage.

C. The transitional Medicaid reimbursement rate is all-inclusive and incorporates the following cost components:

1. direct care staffing;
2. medical/nursing staff, up to 23 hours per day;
3. medical supplies;
4. transportation;
5. administrative; and
6. the provider fee.

D. If the community home meets the above criteria and the individuals served require that the community home has a licensed nurse at the facility 24 hours per day, seven days per week, the community home may apply for a supplement to the transitional rate. The supplement to the rate shall not exceed $25.33 per day per individual.

E. The total transitional Medicaid reimbursement rate, including the supplement, shall not exceed $327.41 per day per individual.

F. The transitional rate and supplement shall not be subject to the following:

1. inflationary factors or adjustments;
2. rebasing;
3. budgetary reductions; or
4. other rate adjustments.

G. Effective for dates of service on or after October 1, 2014, the transitional Medicaid reimbursement rate shall be increased by $1.85 of the rate in effect on September 30, 2014.

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, LR 39:326 (February 2013), amended LR 40:2588 (December 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 44:60 (January 2018), LR 44:772 (April 2018), LR 45:273 (February 2019), LR 45:435 (March 2019).

Chapter 331. Vendor Payments

§33101. Income Consideration in Determining Payment

A. Clients receiving care under Title XIX. The client's applicable income (liability) will be determined when computing the ICF/MR's vendor payments. Vendor payments are subject to the following conditions.

1. Vendor payments will begin with the first day the client is determined to be categorically and medically eligible or the date of admission, whichever is later.

2. Vendor payment will be made for the number of eligible days as determined by the ICF/MR per diem rate less the client's per diem applicable income.

3. If a client transfers from one facility to another, the vendors' payment to each facility will be calculated by multiplying the number of eligible days times the ICF/MR per diem rate less the client's liability.

B. Client Personal Care Allowance. The ICF/MR will not require that any part of a client's personal care allowance be paid as part of the ICF/MR's fee. Personal care allowance is an amount set apart from a client's available income to be used by the client for his/her personal use. The amount is determined by DHH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:682 (April 1999), repromulgated LR 31:2257 (September 2005).

§33103. Payment Limitations

A. Temporary Absence of the Client. A client's temporary absence from an ICF/ID will not interrupt the monthly vendor payment to the ICF/ID, provided the following conditions are met:

1. the ICF/ID keeps a bed available for the client's return; and

2. the absence is for one of the following reasons:

a. hospitalization, which does not exceed seven days per hospitalization; or

b. leave of absence. A temporary stay outside the ICF/ID provided for in the client's written individual habilitation plan. A leave of absence will not exceed 45 days per fiscal year (July 1 through June 30) and will not exceed 30 consecutive days in any single occurrence. Certain leaves of absence will be excluded from the annual 45-day limit as long as the leave does not exceed the 30-consecutive day limit and is included in the written individual habilitation plan. These exceptions are as follows:

i. Special Olympics;
ii. roadrunner-sponsored events;
iii. Louisiana planned conferences;
iv. trial discharge leave;
v. official state holidays; and
vi. two days for bereavement of close family members.

(a). *Close Family Members*—parent, step-parent, child, step-child, brother, step-brother, sister, step-sister, spouse, mother-in-law, father-in-law, grand-parent, or grand-child.

NOTE: Elopements and unauthorized absences under the individual habilitation plan count against allowable leave days. However, Title XIX eligibility is not affected if the absence does not exceed 30 consecutive days and if the ICF/ID has not discharged the client.

3. the period of absence shall be determined by counting the first day of absence as the day on which the first 24-hour period of absence expires;

4. a period of 24 continuous hours or more shall be considered an absence. Likewise, a temporary leave of absence for hospitalization or a home visit is broken only if the client returns to the ICF/ID for 24 hours or longer;

5. upon admission, a client must remain in the ICF/ID at least 24 continuous hours in order for the ICF/ID to submit a payment claim for a day of service or reserve a bed;

EXAMPLE: A client admitted to an ICF/ID in the morning and transferred to the hospital that afternoon would not be eligible for any vendor payment for ICF/ID services.

6. if a client transfers from one facility to another, the unused leave days for the fiscal year also transfer. No additional leave days are allocated as a result of a transfer;

7. the ICF/ID shall promptly notify DHH of absences beyond the applicable thirty- or seven-day limitations. Payment to the ICF/MR shall be terminated from the thirty-first or eighth day, depending upon the leave of absence. Payment will commence after the individual has been determined eligible for Title XIX benefits and has remained in the ICF/ID for 30 consecutive days;

8. the limit on Title XIX payment for leave days does not mean that further leave days are prohibited when provided for in the individual habilitation plan. After the Title XIX payment limit is met, further leave days may be arranged between the ICF/ID and the client, family or responsible party. Such arrangements may include the following options.

a. The ICF/ID may charge the client, family or responsible party an amount not to exceed the Title XIX daily rate.

b. The ICF/ID may charge the client, family or responsible party a portion of the Title XIX daily rate.

c. The ICF/ID may absorb the cost into its operation costs.

B. Temporary Absence of the Client Due to Evacuations. When local conditions require evacuation of ICF/ID residents, the following procedures apply.

1. When clients are evacuated to a family's or friend's home at the ICF/ID's request, the ICF/MR shall not submit a claim for a day of service or leave day, and the client's liability shall not be collected.

2. When clients go home at the family's request or on their own initiative, a leave day shall be charged.

3. When clients are admitted to the hospital for the purpose of evacuation of the ICF/ID, Medicaid payment shall not be made for hospital charges.

C. Payment Policy in regard to Date of Admission, Discharge, or Death

1. Medicaid (Title XIX) payments shall be made effective as of the admission date to the ICF/ID. If the client is medically certified as of that date and if either of the following conditions is met:

a. the client is eligible for Medicaid benefits in the ICF/ID (excluding the medically needy); or

b. the client was in a continuous institutional living arrangement (nursing home, hospital, ICF/ID, or a combination of these institutional living arrangements) for 30 consecutive days; the client must also be determined financially eligible for medical assistance.

2. The continuous stay requirement is:

a. considered met if the client dies during the first 30 consecutive days;

b. not interrupted by the client's absence from the ICF/ID when the absence is for hospitalization or leave of absence which is part of the written individual habilitation plan.

3. The client's applicable income is applied toward the ICF/ID fee effective with the date Medicaid payment is to begin.

4. Medicaid payment is not made for the date of discharge; however, neither the client, the family, nor responsible party is to be billed for the date of discharge.

5. Medicaid payment is made for the day of client's death.

NOTE: The ICF/ID shall promptly notify LDH/BHSF of admissions, death, and/or all discharges.

D. Advance Deposits

1. An ICF/ID shall neither require nor accept an advance deposit from an individual whose Medicaid (Title XIX) eligibility has been established.

EXCEPTION: An ICF/ID may require an advance deposit for the current month only on that part of the total payment which is the client's liability.

2. If advance deposits or payments are required from the client, family, or responsible party upon admission when Medicaid (Title XIX) eligibility has not been established, such a deposit shall be refunded or credited to the person upon receipt of vendor payment.

E. Retroactive Payment. When individuals enter an ICF/ID before their Medicaid (Title XIX) eligibility has been established payment for ICF/ID services is made retroactive to the first day of eligibility after admission.

F. Timely Filing for Reimbursements. Vendor payments cannot be made if more than 12 months have elapsed between the month of initial services and submittal of a claim for these services. Exceptions for payments of claims over 12 months old can be made with authorization from LDH/BHSF only.

G. Refunds to Clients

1. When the ICF/ID receives vendor payments, it shall refund any fees for services collected from clients, family or responsible party by the end of the month in which vendor payment is received.

2. Advance payments for a client's liability (applicable income) shall be refunded promptly if he/she leaves the ICF/ID.

3. The ICF/ID shall adhere to the following procedures for refunds.

a. The proportionate amount for the remaining days of the month shall be refunded to the client, family, or the responsible party no later than 30 days following the date of discharge. If the client has not yet been certified, the procedures spelled out in §33103.G.1 above shall apply.

b. No penalty shall be charged to the client, family, or responsible party even if the circumstances surrounding the discharge occurred as follows:

i. without prior notice; or

ii. within the initial month; or

iii. within some other "minimum stay" period established by the ICF/ID.

c. Proof of refund of the unused portion of the applicable income shall be furnished to BHSF upon request.

H. ICF/ID Refunds to the Department

1. Nonparticipating ICF/ID. Vendor payments made for services performed while an ICF/ID is in a nonparticipating status with the Medicaid Program shall be refunded to the department.

2. Participating ICF/ID. A currently participating Title XIX, ICF/ID shall correct billing or payment errors by use of appropriate adjustment void or patient liability (PLI) adjustment forms.

I. Sitters. An ICF/ID will neither expect nor require a client to have a sitter. However, the ICF/ID shall permit clients, families, or responsible parties directly to employ and pay sitters when indicated, subject to the following limitations.

1. The use of sitters will be entirely at the client's, family's, or responsible party's discretion. However, the ICF/ID shall have the right to approve the selection of a sitter. If the ICF/ID disapproves the selection of the sitter, the ICF/ID will provide written notification to the client, family, and/or responsible party, and to the department stating the reasons for disapproval.

2. Payment to sitters is the direct responsibility of the client, family or responsible party, unless:

a. the hospital's policy requires a sitter;

b. the attending physician requires a sitter; or

c. the individual habilitation plan (IHP) requires a sitter.

NOTE: Psychiatric Hospitals are excluded from this requirement.

3. Payment to sitters is the direct responsibility of the ICF/ID facility when:

a. the hospital's policy requires a sitter and the client is on hospital leave days;

b. the attending physician requires a sitter;

c. the IHP requires a sitter.

4. A sitter will be expected to abide by the ICF/ID's rules, including health standards and professional ethics.

5. The presence of a sitter does not absolve the ICF/ID of its full responsibility for the client's care.

6. The ICF/ID is not responsible for providing a sitter if one is required while the resident is on home leave.

J. Tips. The ICF/ID shall not permit tips for services rendered by its employees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:682 (April 1999), LR 31:1082 (May 2005), repromulgated LR 31:2257 (September 2005), amended by the Department of Health, Bureau of Health Services Financing, LR 43:325 (February 2017), LR 44:61 (January 2018).

§33105. Evacuation and Temporary Sheltering Costs

A. Intermediate care facilities for persons with intellectual disabilities required to participate in an evacuation, as directed by the appropriate parish or state official, or which act as a host shelter site may be entitled to reimbursement of its documented and allowable evacuation and temporary sheltering costs.

1. The expense incurred must be in excess of any existing or anticipated reimbursement from any other sources, including the Federal Emergency Management Agency (FEMA) or its successor.

2. ICFs/ID must first apply for evacuation or sheltering reimbursement from all other sources and request that the department apply for FEMA assistance on their behalf.

3. ICFs/ID must submit expense and reimbursement documentation directly related to the evacuation or temporary sheltering of Medicaid residents to the department.

B. Eligible Expenses. Expenses eligible for reimbursement must occur as a result of an evacuation and be reasonable, necessary, and proper. Eligible expenses are subject to audit at the department’s discretion and may include the following.

1. Evacuation Expenses. Evacuation expenses include expenses from the date of evacuation to the date of arrival at a temporary shelter or another ICF/ID. Evacuation expenses include:

a. resident transportation and lodging expenses during travel;

b. nursing staff expenses when accompanying residents, including:

i. transportation;

ii. lodging; and

iii. additional direct care expenses, when a direct care expense increase of 10 percent or more is documented:

(a). the direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department;

c. any additional allowable costs that are directly related to the evacuation and that would normally be allowed under the ICF/ID rate methodology.

2. Non-ICF/ID Facility Temporary Sheltering Expenses. Non-ICF/ID facility temporary sheltering expenses include expenses from the date the Medicaid residents arrive at a non-ICF/ID facility temporary shelter to the date all Medicaid residents leave the shelter. A non-ICF/ID facility temporary shelter includes shelters that are not part of a licensed ICF/ID and are not billing for the residents under the ICF/ID reimbursement methodology or any other Medicaid reimbursement system. Non-ICF/ID facility temporary sheltering expenses may include:

a. additional nursing staff expenses including:

i. lodging; and

ii. additional direct care expenses, when a direct care expense increase of 10 percent or more is documented:

(a). the direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department;

b. care-related expenses incurred in excess of care-related expenses prior to the evacuation;

c. additional medically necessary equipment such as beds and portable ventilators that are not available from the evacuating nursing facility and are rented or purchased specifically for the temporary sheltered residents; and

i. these expenses will be capped at a daily rental fee not to exceed the total purchase price of the item;

ii. the allowable daily rental fee will be determined by the department;

d. any additional allowable costs as determined by the department and that are directly related to the temporary sheltering and that would normally be allowed under the ICF/ID reimbursement methodology.

3. Host ICF/ID Temporary Sheltering Expenses. Host ICF/ID temporary sheltering expenses include expenses from the date the Medicaid residents are admitted to a licensed ICF/ID to the date all temporary sheltered Medicaid residents are discharged from the ICF/ID, not to exceed a six-month period.

a. The host ICF/ID shall bill for the residents under Medicaid's ICF/ID reimbursement methodology.

b. Additional direct care expenses may be submitted when a direct care expense increase of 10 percent or more is documented.

i. The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department.

C. Payment of Eligible Expenses

1. For payment purposes, total eligible Medicaid expenses will be the sum of nonresident-specific eligible expenses multiplied by the facility's Medicaid occupancy percentage plus Medicaid resident-specific expenses.

a. If Medicaid occupancy is not easily verified using the evacuation resident listing, the Medicaid occupancy from the most recently filed cost report will be used.

2. Payments shall be made as quarterly lump-sum payments until all eligible expenses have been submitted and paid. Eligible expense documentation must be submitted to the department by the end of each calendar quarter.

3. All eligible expenses documented and allowed under §33105 will be removed from allowable expenses when the ICF/ID's Medicaid cost report is filed. These expenses will not be included in the allowable cost used to set ICF/ID reimbursement rates in future years.

a. Equipment purchases that are reimbursed on a rental rate under §33105.B.2.c may have their remaining basis included as allowable cost on future costs reports provided that the equipment is in the ICF/ID and being used. If the remaining basis requires capitalization then depreciation will be recognized.

4. Payments shall remain under the upper payment limit cap for ICFs/ID.

D. When an ICF/ID resident is evacuated to a temporary sheltering site (an unlicensed sheltering site or a licensed ICF/ID) for less than 24 hours, the Medicaid vendor payment to the evacuating facility will not be interrupted.

E. When an ICF/ID resident is evacuated to a temporary sheltering site (an unlicensed sheltering site or a licensed NF) for greater than 24 hours, the evacuating ICF/ID may submit the claim for Medicaid vendor payment for a maximum of five days, provided that the evacuating ICF/ID provides sufficient staff and resources to ensure the delivery of essential care and services to the resident at the temporary shelter site.

F. When an ICF/ID resident is evacuated to a temporary shelter site, which is an unlicensed sheltering site, for greater than five days, the evacuating ICF/ID may submit the claim for Medicaid vendor payment for up to an additional 15 days, provided that the evacuating ICF/ID:

1. has received an extension to stay at the unlicensed shelter site; and

2. provides sufficient staff and resources to ensure the delivery of essential care and services to the resident, and to ensure the needs of the resident are met.

G. When an ICF/ID resident is evacuated to a temporary shelter site, which is a licensed ICF/ID, for greater than 5 days, the evacuating ICF/ID may submit the claim for Medicaid vendor payment for an additional period, not to exceed 55 days, provided that:

1. the host/receiving ICF/ID has sufficient licensed and certified bed capacity for the resident, or the host/receiving ICF/ID has received departmental and/or CMS approval to exceed the licensed and certified bed capacity for a specified period; and

2. the evacuating ICF/ID provides sufficient staff and resources to ensure the delivery of essential care and services to the resident, and to ensure the needs of the resident are met.

H. If an ICF/ID resident is evacuated to a temporary shelter site which is a licensed ICF/ID, the receiving/host ICF/ID may submit claims for Medicaid vendor payment under the following conditions:

1. beginning day two and continuing during the "sheltering period" and any extension period, if the evacuating nursing home does not provide sufficient staff and resources to ensure the delivery of essential care and services to the resident and to ensure the needs of the residents are met;

2. upon admission of the evacuated residents to the host/receiving ICF/ID; or

3. upon obtaining approval of a temporary hardship exception from the department, if the evacuating ICF/ID is not submitting claims for Medicaid vendor payment.

I. Only one ICF/ID may submit the claims and be reimbursed by the Medicaid Program for each Medicaid resident for the same date of service.

J. An ICF/ID may not submit claims for Medicaid vendor payment for non-admitted residents beyond the expiration of its extension to exceed licensed (and/or certified) bed capacity or expiration of its temporary hardship exception.

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, LR 43:327 (February 2017).

LOUISIANA DEPARTMENT OF HEALTH

INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITES (ICF/IID) PROVIDER MANUAL

Chapter Twenty-Six of the Medicaid Services Manual

Issued October 1, 2010

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

INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

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OVERVIEW

Services provided by Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IID) are designed for those individuals diagnosed as having developmental lags which are considered amendable to treatment in a 24-hour managed care environment where they will achieve maximum growth. Individuals are admitted to an ICF/IID after it has been determined by an interdisciplinary professional team that admission is the best available plan.

This chapter specifies the requirements in maintaining an ICF/IID. This document is a combination of federal laws, state laws and Louisiana Department of Health (LDH) regulations and policy. It is not all inclusive of the regulatory process. Providers should also refer to the ICF/IID Federal regulations found at 42 CFR Part 483, the LDH published ICF/IID Standards for Payment and the LDH-HSS Minimum Licensing Standards. There is no intent to include contradictory statements in this manual. If there is a conflict between material in these standards and the federal and state laws or policies governing the program, the state laws or policies governing the program have precedence. These standards provide the ICF/IID with information necessary to fulfill the provider enrollment contract with the agency. The Standards for Payment will take precedence over the language in the manual chapter.

The standards set forth in this and subsequent sections comply with the Title XIX requirements of the amended Social Security Act. That Act sets the standards for the care, treatment, health, safety, welfare and comfort of medical assistance recipients in facilities providing ICF/IID services. These standards apply to ICF/IIDs certified and enrolled by LDH for vendor participation in the Louisiana Medicaid program and supplement current licensing requirements applicable to ICF/IIDs. Any infraction of these standards may be considered a violation of the provider agreement between LDH and the ICF/IID

If any of these standards are not maintained, LDH will determine whether facility certification will continue with deficiencies as allowed under Title XIX regulations or whether termination of the Provider Agreement is warranted. During the determination period, vendor payment will not be suspended. However, deficiencies, which may affect the health, safety, rights, and welfare of the recipients, must be corrected expeditiously in order for the ICF/IID to continue to participate and to operate as a licensed ICF-IID facility.

If a certified ICF/IID is found to have deficiencies which immediately jeopardize the health, safety, rights, and welfare of its recipients, LDH may impose interim sanctions or initiate proceedings to terminate the ICF/IID's certification or licensure in accordance with minimum licensing standards.

Monitoring of an ICF/IID's compliance with state and federal regulations is the responsibility of LDH's Bureau of Health Services Financing (BHSF). The BHSF Health Standards Section is responsible for determining an ICF/IID's compliance with state licensing requirements and compliance with specific Title XIX certification requirements.

ADMISSION PROCESS

Interdisciplinary Team (ID Team)

Prior to admission to Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IID), or before authorization for payment, an interdisciplinary team of health professionals will complete a comprehensive medical, social and psychological evaluation of each individual's need for care in the ICF/IID. As appropriate, other professionals will be included on the team, and at least one member will meet the definition of Qualified Mental Retardation Professional (QMRP). Participation of a nursing professional on this team shall be by a Louisiana licensed registered nurse.

Exploration of Alternative Services

If the comprehensive evaluations recommend ICF/IID services for an individual whose needs could be met by alternative services that are unavailable, this information will be entered into the individual's record. The ICF/IID will also seek alternative services for this individual.

ICF/IID Submission of Data

Evaluative data for medical certification for ICF/IID level of care will be submitted to the appropriate Human Services District or Human Services Authority on each individual. This information will include the following:

- Initial application;
- Applications for individuals transferring from one ICF/IID to another;
- Applications for individuals transferring from an acute care hospital to an ICF/IID;
- Applications for individuals who are patients in a mental health facility;
- Applications for individuals already in an ICF/IID program;
- Applications for individuals being readmitted; and
- Applications for individuals who are being converted from private pay to Medicaid coverage.

A complete packet of admission information must be received by BHSF/Human Services District or Authority **within 20 working days** following the completion of the Individual Habilitation Plan (IHP) for newly admitted individuals. Please note the following:

- Notice within the 20-day time frame will also be required for readmission and transfers.
- If an incomplete packet is received, denial of certification will be issued with the reasons(s) for denial.
- If additional information is subsequently *received within* the initial 20 working day time frame, and the individual meets all requirements, the effective date of certification is the date of admission.
- If the additional information is *received after* the initial 20 working day time frame and the individual meets all requirements, *the effective date is no earlier than the date a completed packet is received by OCDD.*

Data may be submitted before admission of the individual if all other conditions for the admission are met.

Requirements for Certification

The following documentation and procedures are required to obtain medical certification for ICF/IID Medicaid vendor payment. The documentation should be submitted to the appropriate Human Services Authority or Human Services District.

Social Evaluation

The social evaluation must not be completed more than 90 days prior to admission and no later than the date of admission and must address the following:

- Family, educational and social history including any previous placements;
- Treatment history that discusses past and current interventions, treatment effectiveness and negative side effects;
- Current living arrangements;
- Family involvement, if any;

- Availability and utilization of community, educational, and other sources of support;
- Habilitation needs;
- Family and/or individual expectations for services;
- Prognosis for independent living; and
- Social needs and recommendation for ICF/IID placement.

Psychological Evaluation

A psychological evaluation must not be completed more than 90 days prior to admission and no later than the date of admission and must include the following components:

- Comprehensive measurement of intellectual functioning;
- Developmental and psychological history and an assessment of current psychological functioning;
- Measurement of adaptive behavior using multiple informants when possible;
- Statements regarding the reliability and validity of informant data including discussion of potential informant bias;
- Detailed description of adaptive behavior strengths and functional impairments in self-care, language, learning, mobility, self-direction, and capacity for independent living;
- Discussion of whether impairments are due to a lack of skills or noncompliance and whether reasonable learning opportunities for skill acquisition have been provided;
- Recommendations for least restrictive treatment alternative, habilitation and custodial needs. The individual's need for supervision and monitoring to ensure his/her safety; and
- Diagnosis/Diagnoses conforming to the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

If an intellectual assessment is attempted, but cannot be completed, documentation will include the assessment tool attempted and an explanation as to why the assessment could not be completed.

If an updated psychological evaluation is submitted, the agency will submit the prior comprehensive psychological report that is referenced in the update.

Psychiatric Evaluation

A psychiatric evaluation must be completed if the individual has a primary or secondary diagnosis of mental illness, is receiving psychotropic medication, has been hospitalized in the past three years for psychiatric problems, or if significant psychiatric symptoms were noted in the psychological evaluation or social assessment. The psychiatric evaluation shall not be completed more than 90 days prior to admission and no later than the date of admission. The psychiatric evaluation should include the following:

- History of present illness;
- Mental status exam;
- Diagnostic impression;
- Assessment of strengths and weaknesses;
- Recommendations for therapeutic interventions; and
- Prognosis.

A psychiatric evaluation may be requested at the discretion of OCDD to determine the appropriateness of placement if admission material indicates the possible need for psychiatric intervention due to behavior problems.

Other Evaluations

Additional evaluations may be requested when the individual currently receives or is in need of one or more of the following therapies:

- Physical;
- Occupational; or
- Speech.

Individual Service Plan

The individual service plan (ISP), which may also be referred to as the Support Plan, developed by the interdisciplinary team within 30 days of admission, shall include the following:

- Habilitation needs;
- Specific assessment based objectives;
- Specific services, accommodations, and/or equipment needed to assist the individual's placement in an ICF/IID; and
- Participation by the individual, the parent(s), or legal guardian unless impossible or inappropriate. If the individual is a competent major, the family or advocate participation is only allowed with the consent of the individual. The ISP team minutes with signatures from the participant or legal guardian must be submitted with the ISP.

NOTE: Document the reason(s) for ANY non-participation by the individual, the individual's parent(s), or the individual's legal guardian.

Form 90-L

A request for Level of Care Determination (Form 90-L) must be submitted on each admission or readmission. This form must:

- Not be completed more than 30 days before admission and not later than the date of admission;
- Be fully completed and include prior living arrangements and previous institutional care;
- Be signed and dated by a physician licensed to practice in Louisiana. ***Certification will not be effective any earlier than the date the Form 90-L is signed and dated by the physician;***
- Include a diagnosis of developmental disability or related condition as well as any other medical condition; and
- Indicate the ICF/IID level of care.

Form 148

A Notification of Admission or Change (Form 148) must be submitted for each new admission and when there is a change in a recipient's status such as, death, discharge, transfer, or readmission from a hospital.

For individuals whose application for Medicaid is later than the date of admission, the date of application must be indicated on the form.

Inventory for Client and Agency Planning

The Inventory for Client and Agency Planning (ICAP) assessment must be submitted for each new admission. The ICAP should be completed no more than 90 days prior to date of admission and no later than 30 calendar days after the date of admission.

Statement of Approval

The participant must have a current Statement of Approval from a Human Services District or Authority.

Transfers

Transfer within an Organization

The following must be completed for a recipient transferring from an organization:

- Form 148 must be submitted by both the discharging facility and the admitting facility.
- Form 148 shall indicate the date the recipient was discharged from the transferring facility, the name of the receiving facility, and the date of admission.
- An updated individual service plan must be submitted by the discharging facility to the receiving facility. The receiving facility ID team may adjust the ISP if they feel it is necessary.

The receiving facility must submit minutes of an ID team meeting addressing the reason(s) for the transfer, the family and recipient's response to the move, and the signatures of the persons attending the meeting.

Transfer of a Recipient outside the Organization

Certification requirements involving the transfer of a recipient from one ICF/IID to another (which is not part of the same organization or network) will be treated the same as for a new admission. Therefore, the receiving facility must follow all the steps for a new admission. The discharging facility will notify OCDD of the discharge by submitting Form 148 giving the date of discharge and destination.

Transfer from an ICF/IID to a Nursing Facility

When a recipient's medical condition has deteriorated to the extent that he/she cannot participate in or benefit from active treatment and requires 24-hour nursing care, the ICF/IID may request prior approval from OCDD to transfer the recipient to a nursing facility by submitting the following information:

- Form 148 showing that transfer to a nursing facility is being requested;
- Form 90-L completed within 30 days prior to request for transfer indicating that nursing facility level of care is needed; and
- Level 1 PASRR completed within 30 days prior to request for transfer.

The ID team meeting minutes must address the reason for the transfer, along with the family and recipient's response to the move and the signature of the persons attending the meeting, and any other medical information that will support the need for nursing facility placement.

Readmission to the Facility

Readmission Following Hospitalization

The Form 148 must be submitted showing the date Medicaid billing was discontinued and the date of readmission to the facility.

Documentation must be submitted that specifies the recipient's diagnosis, medication regime, and include the physician's signature and date. The documentation can be one of the following:

- Form 90-L;
- Hospital transfer form;
- Hospital discharge summary; or

- Physician's orders.

An updated ISP must be submitted to the local OCDD Regional Office/Human Services Authority or Human Services District showing changes, if any, as a result of the hospitalization.

Readmission Following Exhausted Home Leave Days

The following documentation must be submitted for readmission following exhausted Home Leave days:

- Form 148 showing the date billing was discontinued and the date of readmission; and
- An updated ISP showing changes, if any, as a result of the extended home leave.

COVERED SERVICES

The primary purpose of an Intermediate Care Facility for individual(s) with Intellectual Disabilities (ICF/IID) is to provide habilitative or health services to individuals with an intellectual disability. The facility must provide internal or external active treatment program interventions and services as to support the achievement of the objectives identified in the individual habilitation plan (IHP), which is also referred to as the ISP. These services include, but are not limited to, occupational, speech, physical and recreational therapies; psychological, psychiatric, audiological, social work, special education, dietary and rehabilitation counseling.

NOTE: Supplies, equipment, etc., needed to meet the goals of the IHP cannot be charged to the recipients or their responsible parties.

Active Treatment Components

Individual Habilitation Plan

Each recipient must have an IHP developed by an interdisciplinary team that represents the professions or resource areas that are relevant to that recipient's needs.

At the recipient's staffing conference, the team member's presence or absence must be documented in the IHP, as well as the reasons for the absence. Within 30 days after admission, the interdisciplinary team must complete assessments or reassessments to supplement the evaluation conducted prior to admission. The team must prepare for each recipient an IHP that states specific objectives necessary to meet the recipient's needs, and a plan for achieving these objectives. These objectives are derived from the comprehensive functional assessment. The comprehensive functional assessment must take into consideration the recipient's age and contain the following:

- The presenting problems and disabilities, including diagnosis, symptoms, complaints and complications;
- The recipient's specific developmental strengths;
- The recipient's specific developmental and behavioral management needs; and
- An identification of the recipient's needs for services.

The comprehensive functional assessment must cover the following developmental areas:

- Physical development and health;

- Nutritional status;
- Sensorimotor development;
- Affective development;
- Speech and language development;
- Auditory functioning;
- Cognitive development;
- Social development;
- Adaptive behaviors or independent living skills necessary for the recipient to be able to function in the community;
- Vocational skills as applicable; and
- Psychological development.

Components of specific IHP objectives must be:

- Stated separately, in terms of a single behavior outcome;
- Assigned projected completion dates;
- Expressed in behavior terms that provide measurable indices of performance;
- Organized to reflect a developmental disability; and
- Assigned priorities.

A copy of each recipient's IHP must be made available to all relevant staff, including staff of other agencies who work with the recipient, the recipient's parents, or legal guardian (if the recipient is a minor). The IHP must be implemented within 14 calendar days of its development. The facility must develop and make available to relevant staff an outline of the treatment schedule for the current active treatment program. Each written training program designed to implement these objectives in the IHP shall specify:

- The methods to be used;

- The schedule for use of the methods;
- The person responsible for the program;
- The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;
- The inappropriate recipient behavior(s), if applicable; and
- A provision for the appropriate expression and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

The IHP must describe relevant interventions to support the recipient toward independence that includes training in personal skills essential for privacy and independence such as activities of daily living. These interventions must continue until it has been demonstrated that the recipient is developmentally incapable of applying them. The IHP must also identify the location where program strategy information can be found (this must be accessible to any person responsible for implementation) and plans for discharge.

The IHP must identify any needed supports to achieve proper body position, balance, or alignment and should indicate the schedule, reason, and situations in which each support is applied and used.

Recipients who have multiple disabling conditions must be provided the opportunity to spend a major portion of each day out of bed and outside the bedroom area, whenever possible.

The IHP must include opportunities for recipient choice and self-management.

Documentation

The facility must document data relevant to the accomplishment of IHP objectives. This data must meet the following criteria:

- Be documented in measurable outcomes;
- Include significant events that contribute to an overall understanding of his/her ongoing level and quality of function; and
- Reviewed at least quarterly, or as needed, by a qualified mental retardation professional (QMRP).

In addition, the IHP must be revised as necessary, including but not limited to situations in which the recipient:

- Has successfully completed any objective(s) identified in the individual habilitation plan;
- Is regressing or losing skills;
- Is failing to progress toward identified objectives after reasonable efforts have been made; and
- Is being considered for training toward new objectives.

At least annually, the comprehensive assessment of each recipient must be reviewed by the interdisciplinary (ID) team for relevancy and updated as needed. The IHP must be revised as needed or at least by the 365th day after the last review.

NOTE: For Admission Requirements, refer to section 26.1 of this Chapter.

Professional Services

The health care of each recipient shall be under the continuing supervision of a Louisiana licensed physician. **The facility must ensure the availability of physician services 24 hours a day**. The facility must provide or obtain preventive and general medical care plus annual physical examinations of each recipient. The recipient, the family or the responsible party shall be allowed a choice of physicians. If the recipient does not have a personal physician, the ICF/IID shall provide referrals to physicians in the area, identifying physicians that participate in the Medicaid Program.

NOTE: The cost of physician and nursing services cannot be charged to the recipients or their responsible party.

Nursing Services

The facility must provide each recipient with nursing services as prescribed by the physician, identified by the IHP or as needed.

Nursing services must include:

- The development with a physician, of a **medical care plan of treatment** for a recipient when the physician has determined that the recipient requires such a plan;

- 24-hour nursing service as indicated by the medical care plan or other nursing care as prescribed by the physician or as identified in the recipient's IHP;
- A quarterly review of the individual recipient's health status, or more frequently if needed;
- Recipient and staff training, as needed, in appropriate health and hygiene methods and self-administration of medications; and
- Physician notification of any changes in the recipient's health status.

The facility must have a ***formal*** arrangement with a registered nurse, licensed to practice in Louisiana, to provide or oversee the nursing services for the recipients.

This registered nurse must also be available for verbal or on-site consultation to the licensed practical nurse or to a facility that has no nurse on staff.

Dental Services

The facility must provide or arrange for comprehensive dental diagnosis and treatment services for each recipient. These services are to be provided in-house or through other arrangements by qualified personnel, by licensed dentists and dental hygienists.

The facility must provide comprehensive services that include dental care needed for relief of pain and infections, restoration of teeth, and general dental maintenance. The facility must ensure the availability of emergency treatment on a 24-hour per day basis by a licensed dentist.

NOTE: The cost for these dental services cannot be charged to the recipients or their responsible party.

Pharmaceutical Services

The facility must provide or arrange for the provision of routine and emergency drugs and biologicals for its recipients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

Routine administration of medications shall be done at the facility where the recipient resides. Recipients may not be transported elsewhere for the sole purpose of medication administration.

The ICF/IID shall neither expect, nor require, any provider to give a discount or rebate for prescription services rendered by the pharmacists. The ICF/IID shall order at least a one-month supply of medications from a pharmacy of the recipients, the recipient's family, or responsible

party's choice. Less than a month's supply is ordered only when the attending physician specifies that a smaller quantity of medication is necessary for a special medical reason.

The ICF/IID chief executive officer or the authorized representative shall certify receipt of prescribed medications by signing and dating the pharmacy billing.

NOTE: The cost for drugs and biologicals cannot be charged to the recipient, family, or responsible party including any additional charges for the use of the unit dose or blister pack system of packing and storing medications.

Aids and Equipment

The facility must furnish, maintain in good repair, and teach recipients to use and to make informed choices about the use of dentures, eyeglasses, hearing aids and other communication aids, braces, and other devices identified by the ID team as needed by the recipient.

NOTE: The costs for aids and equipment cannot be charged to the recipients or their responsible party.

Nutritional Services

The facility must provide a nourishing, well-balanced diet for each recipient, including modified and specially prescribed diets. The nutritional component must be under the guidance of a licensed dietitian.

NOTE: Nutritional services are included in the per diem rate. Residents of an ICF/IID are not eligible for food stamps, commodities, or other subsidized food programs.

Clothing

The facility should provide adequate seasonal clothing for the recipient and must maintain a current clothing inventory for each recipient. Adequate is defined as a seven-day supply in good repair and properly fitting. Work uniforms or special clothing/equipment for training will be provided in addition to the seven-day supply. A recipient with adequate clothing may purchase additional clothing using his/her personal funds if he/she desires. If a recipient desires to purchase a certain brand, the recipient has the right to use his/her personal funds in this manner; however, the recipient must be made aware of what the facility is providing prior to making his/her decision. It must be documented that the recipient was made aware of what the facility is obligated to provide.

NOTE: For more information on services that must be provided by the ICF/IID or may be purchased by the recipient, see Section 26.7 Income Consideration in Determining Payment of this manual chapter.

RECIPIENT BEHAVIOR

Written Policies and Procedures

Staff and Recipient Interactions and Conduct

Facilities must have written policies and procedures for the management of conduct between staff and recipients. These policies and procedures will:

- Specify conduct that will be allowed and not allowed by the staff and the recipients;
- Provide for recipient choice and self-determination to the extent possible;
- Be readily available to all recipients, parent(s), staff, and legal guardians; and
- Be developed with the participation of recipients to the extent possible.

Management of Inappropriate Recipient Behavior

A facility must develop and implement written policies and procedures for the management of inappropriate recipient behavior. These policies and procedures must:

- Specify all facility approved interventions to manage inappropriate recipient behavior;
- Designate these interventions on a hierarchy ranging from the most positive and least restrictive to the least positive and most restrictive;
- Insure that, prior to the use of more restrictive techniques, the recipient's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried and were ineffective;
- Address the use of extraordinary and least restrictive measures such as time-out rooms, physical restraints, drugs used to manage inappropriate behavior, and the application of painful or noxious stimuli; and
- Identify the staff members who may authorize use of a particular intervention, and a mechanism for monitoring and controlling use of the intervention.

Interventions to Manage Inappropriate Behavior

Safety and Supervision

Interventions to manage inappropriate recipient behavior must be used within sufficient safeguards and supervision to insure that the safety, welfare, and civil and human rights of recipients are adequately protected. These interventions must never:

- Be used for disciplinary purposes, for the convenience of staff or as a substitute for an active treatment program;
- Include corporal punishment; or
- Include discipline of one recipient by another except as part of an organized system of self-government as set forth in facility policy.

Behavior Management Plan

Individual programs to manage inappropriate recipient behavior such as time-out rooms, restraints, etc. must be incorporated into the recipient's individual habilitation plan (IHP) and must be reviewed, approved, and monitored by the specially constituted Human Rights Committee. Written informed consent by the recipient or responsible party is required prior to implementation of a behavior management plan involving any risks to recipient's rights. See Section 26.4 Recipient Rights in this manual chapter, which addresses informed consent.

Standing Programs

Standing or as needed programs to control inappropriate behavior are not permitted. Sending a recipient to his room to control inappropriate behavior is not acceptable unless it is a part of a systematic program of behavioral interventions for that recipient.

Time-out Rooms

Use of time-out rooms is **NOT** permitted in group or community homes.

In institutional settings (over 16 beds), emergency placement in time out rooms is allowed. It is permitted **only** when professional staff is on-site and only under the following conditions:

- The placement in a time-out room is part of an approved systematic behavior program as required in the IHP to manage inappropriate behavior;
- The recipient is under direct constant visual supervision of designated staff;
- If the door to the room is closed, it must be held shut only by use of constant physical pressure from a staff member;
- Placement in time-out room does not exceed one hour;
- Recipients are protected from hazardous conditions while in time-out rooms; and
- A record is kept of time-out activities.

Physical Restraint

Physical restraint is defined as any manual method or physical or mechanical device that the recipient cannot remove easily and which restricts free movement. Examples of manual methods include therapeutic or basket holds and prone or supine containment. Examples of physical or mechanical devices include barred enclosure that is no more than three feet in height; a chair with a lap tray, to keep an ambulatory recipient seated; a wheelchair tied to prevent movement of a wheelchair mobile recipient; and straps to prevent movement while the recipient is in a chair or bed.

Physical restraints can be used only:

- When absolutely necessary to protect the recipient from injuring him/herself or others in an emergency situation;
- When part of an individual program plan intended to lead to less restrictive means of managing the behavior the restraints are being used to control;
- As a health related protection prescribed by a physician but only if absolutely necessary during a specific medical, dental, or surgical procedure or while a medical condition exists; and
- When the following conditions are met:

- Restraints are designed and used so as not to cause physical injury and to cause the least possible discomfort;
- Restraints are applied only by staff who have had training in the use of these interventions;
- Orders for restraints shall not be obtained for use on a standing or on an as needed basis;
- Restraint authorizations are not in effect longer than 12 consecutive hours and are obtained as soon as possible after restraint has occurred in emergency situations;
- Recipients in restraints shall be checked at least every 30 minutes and released by staff trained in the use of restraints, as soon as the behavior has subsided. Record of restraint checks and usage is required; and
- Opportunities for motion and exercise are provided for not less than 10 minutes during each two-hour period and a record is kept.

Medications

Medications used for control of inappropriate behavior may be used only under the following conditions:

- In doses that do not interfere with the recipient's daily living activities; and
- Must be approved by the interdisciplinary team, the recipient, or legal representative, and the specially constituted committee.

Prescribed medications must be used only as part of the recipient's IHP and is directed toward eliminating the inappropriate behavior.

Prior to the use of any program involving a risk to recipient protection and rights, including the use of prescribed medications to manage inappropriate behavior, obtain written informed consent from:

- Recipient; or
- Family, legal representative, or advocate if recipient is a minor or recipient is unable to understand the intended program or treatment.

Inform consent consists of permission given voluntarily on a time limited basis not to exceed 365 days by the recipient or the legally appropriate party after having been informed of the:

- Specific issue, treatment or procedure;
- Recipient's specific status with regard to the issue;
- Attendant risks regarding the issue;
- Acceptable alternatives to the issue;
- Right to refuse; and
- Consequences of refusal.

Drugs must not be used until it can be justified that the beneficial effects of the prescribed medication on the recipient's behavior clearly outweighs the potentially harmful effects of the drug. Prescribed medication must be clearly monitored in conjunction with the physician, the pharmacist, and facility staff.

If clinical evidence justifies that this is contraindicated, drugs for control of inappropriate behavior must be gradually reduced at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team.

RECIPIENT RIGHTS

Written Policies

The facility will establish written policies that protect recipients' legal rights, promote quality of life, and maintain their sense of dignity and self-determination. The chief executive officer will be responsible for assuring the staff complies with these policies.

Notification of Rights

All recipients, families, and/or responsible parties will sign a statement verifying that they have been fully informed verbally and in writing at the time of admission, and when changes occur during the recipient's stay in the facility, of the following information:

- The facility's rules and regulations;
- The recipients' rights;
- The recipients' responsibilities to obey all rules and regulations and respect the personal rights and private property of the residents; and
- Rules for conduct at the time of recipient admission and subsequent changes during their stay in the facility.

Changes in the recipient rights or responsibilities will be conveyed both verbally and in writing to each recipient, family, and/or responsible party at the time of or before the change.

Receipt of the change will be acknowledged in writing by each capable recipient, family member, and/or responsible party. This written acknowledgment will be witnessed by a third person.

Each recipient must be fully informed in writing of all chargeable services available in the Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/IID). This will include any charges for services not paid for by Medicaid or not included in the facility's basic rate per day charges. The facility must provide this information either before or at the time of admission and on a continuing basis as changes occur in services or charges during the recipient's stay.

Legislation

Civil Rights Act of 1964 (Title VI)

Title VI of the **Civil Rights Act of 1964** states, "No persons in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

The facility will meet the following criteria in regards to the above-mentioned Act:

- **Compliance**

  The facility will be in compliance with **Title VI** of the **Civil Rights Act of 1964** and will not discriminate, separate, or make any distinction in housing, services, or activities based on race, color, or national origin.

- **Written Policies**

  The facility will adopt and implement written policies for compliance with the Civil Rights Act. All employees and contract service providers who provide services to recipients will be notified in writing of the Civil Rights policy.

- **Community Notification**

  The facility will notify the community that the ICF/IID activities and services are provided to recipients without regard to race, color, or national origin. The notice to the community may be given by letters to and meetings with physicians, local health and welfare agencies, paramedical personnel, and public and private organizations having interest in equal opportunity. Notices published in newspapers and signs posted in the facility may also be used to inform the public.

- **Housing**

  All recipients will be housed without regard to race, color, or national origin. ICF/IIDs will not have dual accommodations to effect racial segregation. Biracial occupancy of rooms on a nondiscriminatory basis will be required. There will be a policy prohibiting assignment of rooms by race.

Recipients **will not be asked** if they are willing to share a room with a person of another race, color, or national origin. Recipient transfer will not be used to evade compliance with Title VI of the Civil Rights Act of 1964.Open Admission Policy

An open admission policy and desegregation of the ICF/IID will be required, particularly when the facility previously excluded or primarily serviced recipients of a particular race, color, or national origin. Facilities that exclusively serve recipients of one race have the responsibility for taking corrective action, unless documentation is provided that this pattern has not resulted from discriminatory practices.

- **Recipient Services**

  All recipients will be provided medical, non-medical, and volunteer services without regard to race, color, or national origin. All administrative, medical and non-medical services are covered by this requirement.

  An ICF/IID's staff will provide recipient services without regard to race, color, or national origin.

The facility also must not discriminate in hiring or firing of employees including contractual and consultative capacities.

Section 504 of the Rehabilitation Act of 1973

Facilities will comply with **Section 504** of the **Rehabilitation Act of 1973** that states, "No qualified person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance."

Age Discrimination Act of 1975

This act prohibits discrimination on the basis of age in programs or activities receiving federal financial assistance. All ICF/IIDs must be in compliance with this act.

Americans with Disabilities Act of 1990

All facilities must be in compliance with this act.

Recipient Rights

Resident Bill of Rights

Upon admission to the facility, the ICF/IID shall provide to each recipient or their responsible party a copy of the residents' bill of rights. Each recipient must:

- Be fully informed by a physician of his health and medical condition unless the physician decides that informing the resident is medically contraindicated;
- Be given the opportunity to participate in planning his total care and medical treatment;
- Be given the opportunity to refuse treatment; and
- Give informed, written consent before participating in experimental research.

If the physician decides that informing the recipient of his health and medical condition is medically contraindicated, it must be documented in the recipient's record.

Each recipient must be transferred or discharged in accordance with the discharge plans in the individual habilitation plan (IHP) and/or the procedures on transfers and discharges as stated in this manual. (See Sections 26.2 Covered Services and 26.5 Transfers and Discharges)

Recipients must be encouraged and assisted in exercising their rights as a recipient of the facility and as a citizen. Recipients must be allowed to submit complaints or recommendations concerning the policies and services of the ICF/IID to staff and/or to outside representatives free from restraint, interference, coercion, discrimination, or reprisal. This includes the right to due process.

Recipients must be allowed to manage his/her personal financial affairs and taught to do so to the extent of individual capability. If a recipient requested assistance from the facility in managing his/her personal financial affairs, the request must be in WRITING and the facility must comply with the record keeping requirements of this manual.

Recipients must be free from physical, verbal, sexual or psychological abuse or punishment. Recipients must be free from chemical and physical restraints unless the restraints are used in accordance with recipient health, safety, and habilitation regulations. (Refer to Section 26.3 Recipient Behavior)

Privacy

Recipients must be treated with consideration, respect, and full recognition of their dignity and individuality and must be given privacy during treatment and care of personal needs. Recipients' records, including information in an automated database, must be treated confidentially. Recipients must give written consent before the facility may release information from their records to anyone not authorized by law to receive it.

A married recipient must be given privacy during visits by his/her spouse. If both husband and wife are residents of the facility, they must be permitted to share a room.

No recipient may be required to perform services for the facility. Those recipients who work by choice for the facility must be compensated for their efforts at prevailing wages and commensurate with their abilities.

Each recipient must be allowed to:

- Communicate, associate, and meet privately with individuals of his choice, unless this infringes on the rights of another recipient(s);
- Send and receive personal mail ***unopened***; and
- Have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within his/her IHP.

Recipients must be allowed to participate in social, religious, and community group activities.

Recipients must be allowed to retain and use their personal possessions and clothing as space permits.

Recipients may be allowed to have burial insurance policy(s). The ICF/IID's administrator or designee, with the recipient's permission, may assist the recipient in acquiring a burial policy, provided that the administrator, designee, or affiliated persons derive no financial or other benefit from the resident's acquisition of the policy.

Violation of Rights

A person who submits or reports a complaint concerning a suspected violation of a recipient's rights, services or conditions in an ICF/IID, or who testifies in any administrative or judicial proceeding arising from such complaints, will have immunity from any criminal or civil liability unless that person has acted in bad faith with malicious purpose, or if the court finds that there was an absence of a justifiable issue of either law or fact by the complaining party.

TRANSFERS AND DISCHARGES

Written Agreements with Outside Resources

Each recipient must receive the services that are required to meet his/her needs including emergency and other health care. If the service is not provided by the Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IID), there must be a written agreement with an outside resource. The written agreement for hospital transfers must be with nearby hospitals and provide for prompt transfer of recipients.

Facility Responsibilities for Transfers or Discharges

Facility records shall document that the recipient was transferred or discharged for good cause which means for any reason that is in the best interest of the individual.

Any decision to move a recipient shall be part of an interdisciplinary team process. The recipient, family, legal representative, and advocate (if there is one), shall participate in the decision making process.

Planning for a recipient's discharge or transfer shall allow for at least 30 days to prepare the recipient and parents/guardian for the change (except in cases of emergency);

Planning for release of a recipient shall include providing for appropriate services in the recipient's new environment, including protective supervision and other follow-up services which are detailed in the discharge plan.

The recipient and/or legal representative must give their written consent to all non-emergency situations. Notification shall be made to the parents or responsible parties as soon as possible.

Both the discharging and receiving facilities shall share responsibility for ensuring the exchange of medical and other programmatic information which shall include the following:

- An updated active treatment plan;
- Appropriate care and transportation of the recipient during transfer; and
- The transfer of personal effects and of information related to such items.

Staff from the sending and receiving facilities shall confer on a continuing basis to share pertinent information regarding all aspects of the recipient's care and habilitation training. The

transferring facility is responsible for developing a final summary of the recipient's developmental, behavioral, social, health, and nutritional status. Also, with the consent of the recipient and/or responsible party, a copy of this summary must be provided to authorized persons and agencies.

The facility shall establish procedures for counseling recipients or legal representatives, concerning the advantages and disadvantages of the discharge. This counseling shall include information regarding after care services available through agency and community resources.

All recipients being transferred or discharged shall be given appropriate information about the new living arrangement. Counseling shall be provided if they are not in agreement with this living arrangement. (See Section below on involuntary transfers if recipient is being transferred against his/her will).

The recipient's right to the most appropriate placement that will meet his/her needs shall govern all transfer/discharge planning. **Recipients are not to be maintained in inappropriate placements in which their needs cannot adequately be met**.

Involuntary Transfer or Discharge

Involuntary transfer or discharge of a recipient may occur only under the following conditions:

- The transfer or discharge is necessary for the recipient's welfare and the recipient's needs cannot be met in the facility;
- The transfer or discharge is appropriate because the recipient's health has improved sufficiently, therefore, the recipient no longer needs the services provided by the facility;
- The safety of individuals in the facility is endangered;
- The health of individuals in the facility would otherwise be endangered;
- The recipient has failed, after reasonable and appropriate notice, to pay for the portion of the bill for services which he/she is liable or when the recipient loses financial eligibility for Medicaid; or
- The facility ceases to operate.

NOTE: When a recipient becomes eligible for Medicaid after admission to a facility, the facility may charge the recipient only allowable charges under Medicaid.

Facility Responsibilities

When a recipient is involuntarily transferred or discharged, the recipient's clinical record must be fully documented and documentation must be made by the following:

- **The recipient's physician -** if the transfer or discharge is necessary for the recipient's welfare or the recipient's condition has sufficiently improved and no longer needs the services provided by the facility; or

- **Any physician** - if the health of the individuals in the facility would be endangered.

Before an inter-facility transfer or discharge occurs, the facility must:

- Notify the recipient of the transfer or discharge and the reason for the move. The notification must be written in a language and manner that the recipient understands. A copy of the notice must be placed in the recipient's clinical record and transmitted to:

    - The recipient;
    - A family member of the recipient, if known;
    - The recipient's legal representative and legal guardian, if known;
    - The Community Living Ombudsman Program;
    - The Louisiana Department of Health (LDH) Health Standards Section;
    - OCDD regional office for assistance with the placement decision;
    - The recipient's physician;
    - Appropriate educational authorities; and
    - A representative of the recipient's choice.

- Record the reasons in the recipient's clinical records.

- Conduct an interdisciplinary team conference with the recipient, family member or legal representative and an appropriate agency representative to update the plan and develop discharge options that will provide a reasonable assurance that the transfer or discharge is to a setting that can be expected to meet the recipient's needs.

The facility must issue the written notice of discharge or transfer at least 30 days before the recipient is transferred or discharged. However, the notice may be made as soon as practicable before transfer or discharge under the following circumstances:

- The safety of the individuals in the facility would be endangered;
- The health of individuals in the facility would be endangered;
- The recipient's health improves sufficiently to allow a more immediate transfer or discharge; or
- An immediate transfer or discharge is required by the recipient's urgent medical needs as determined by a physician.

NOTE: Notice may be made at least 15 days before transfer or discharge in cases of nonpayment of a bill for cost of care.

The written notice must include:

- The reason for transfer or discharge;
- The effective date of transfer or discharge;
- Location to which the recipient is transferred or discharged;
- An explanation of the recipient's right to have personal and/or third party representation at all stages of the transfer or discharge process;
- The address and telephone number of the Community Living Ombudsman Program;
- The mailing address and telephone number of the agency responsible for the protection of individuals with developmental disabilities;
- Names of facility personnel available to assist the recipient and family in decision making and transfer arrangements;
- Date, time and place for the follow-up interdisciplinary team conference to make a final decision on the recipient's/legal representative's choice of new facility or alternative living arrangement; and

- An explanation of the recipient's right to register a complaint with LDH within three days after the follow-up interdisciplinary team conference.

The facility shall provide all services required prior to discharge that are contained in the final update of the individual habilitation plan and in the transfer or discharge plan.

The facility shall be responsible for keeping the recipient, whenever medical or other conditions warrant, for as long as necessary even if beyond the proposed date of transfer or discharge, except in emergency situations.

The facility shall provide transportation to the new residence unless other arrangements are preferred by the recipient/legal representative or the receiving facility.

If a recipient requests a hearing, LDH shall hold a hearing at the ICF/IID, or by telephone if agreed upon by the appellant, within 30 days from the date the appeal is filed with the Division of Administration (DAL) and witness and exhibit lists are submitted by the facility. The DAL shall issue a decision within 30 days from the date of the recipient's hearing.

OCDD Regional Office Responsibilities

OCDD Regional Office responsibilities when involuntary transfer or discharge occurs include the following:

- Review written notice of involuntary discharge;
- Ensure that the recipient's rights are protected during transfer;
- Refer any rights violations to BHSF Health Standards State Office for investigation; and
- Complete medical certification for receiving facility after review of appropriate data.

BHSF Medicaid Eligibility Local Office Responsibilities

When an involuntary transfer or discharge occurs, the local office is responsible for the following:

- Referring complaints related to health care filed by recipients, recipients' families or legal representatives to LDH Health Standards State Office for investigation; and

- Completing financial eligibility determination for transfer to appropriate facility or non-institutional living arrangement.

Mass Transfer of Recipients

The following provisions shall apply to any mass transfer.

ICF/IID Decertification

When BHSF determines that an ICF/IID no longer meets State and Federal Title XIX certification requirements, decertification action is taken. Usually an advance decertification date is set, unless the recipients are in immediate danger.

ICF/IID Decertification Notice

On the date the ICF/IID is notified of its decertification, OCDD shall immediately begin notifying recipients, families, responsible parties, and other appropriate agencies or individuals of the decertification action and of the services available to ensure an orderly transfer and continuity of care.

Coordination of Decertification Process

The process of decertification requires concentrated and prompt coordination among the following groups: the BHSF Health Standards regional office, BHSF Medicaid eligibility parish office, the facility, OCDD, and other offices designated by LDH.

The coordination effort shall have the following objectives:

- Protection of recipients;

- Assistance in finding the most appropriate placements for recipients when requested by recipients, families and/or responsible parties; and

- Timely termination of vendor payment upon recipients' discharge from the ICF/IID.

NOTE: The ICF/IID still retains its usual responsibility during the transfer/discharge process to notify the BHSF Medicaid Eligibility Parish Office promptly of all changes in the recipient's status.

ICF/IID Closing or Withdrawing from the Medicaid Program

When an ICF/IID either voluntarily or involuntarily discontinues its operations or participation in the Medicaid Program, recipients, families, responsible parties, and other appropriate agencies or individuals must be given sufficient notice of the effective closure date to insure an orderly transfer and continuity of care.

If the ICF/IID is voluntarily or involuntarily **withdrawing** from Medicaid participation, the recipient has the option of remaining in the ICF/IID on a private-pay basis.

If the ICF/IID is **closing** its operations, plans shall be made for transfer.

Payment Limitation

Payments may continue for recipients up to 30 days following the effective date of the ICF/IID's decertification. However, no payment will be approved for Medicaid recipients admitted after an ICF/IID receives a notice of decertification. The payment limitation also applies to Medicaid recipients admitted prior to the decertification notice.

Payment will continue for recipients certified prior to the decertification **only** if the ICF/IID totally cooperates in the orderly transfer of recipients to other Medicaid facilities or other placements of their choice.

Transfer Team

LDH shall designate certain staff members as a transfer team when a mass transfer is necessary. The team's responsibilities shall include supervising transfer activities in the event of a proposed ICF/IID decertification or voluntary termination of Medicaid participation.

This team is responsible for:

- **Identification and Coordination**

  When a provider agreement is extended for up to two months beyond its original expiration date, the transfer team shall immediately identify the ICF/IID receiving the affected recipients, and determine the last date for which vendor payment for recipient services can be made. The team members will assist in making the most

appropriate arrangements for the recipients, by providing members names as contact persons if assistance is needed.

- **Supervision and Assistance**

  When payments are continued for up to 30 days following decertification, the transfer team shall supervise the decertification and transfer of its Medicaid recipients. The team will assist in making the most appropriate arrangements for the recipients, by providing the members' names as contact persons if assistance is needed. They will also determine the last date for which vendor payment for recipient services can be made.

- **Effecting the Transfer**

  In order to insure an orderly transfer or discharge, the transfer team shall also be responsible for performing the following tasks:

  - Meeting with appropriate ICF/IID administrative staff and other personnel as soon as possible after termination of a provider agreement to discuss the transfer planning process;
  - Continuing to meet periodically with the ICF/IID personnel throughout the transfer planning process;
  - Identifying any potential problems;
  - Monitoring the ICF/IID's compliance with transfer procedures;
  - Resolving disputes in the recipients' best interest;
  - Encouraging the ICF/IID to take an active role in the transfer planning;
  - Arranging for the social services necessary in the transfer or discharge plan or otherwise necessary to insure an orderly transfer or discharge; and
  - Obtaining other services available under Medicaid.

NOTE: The ICF/IID's failure to comply with the transfer team's requests may result in denial of reimbursement during the extension period.

BHSF Medicaid Eligibility Local Office Responsibilities

The BHSF Medicaid Eligibility Local Office is responsible for maintaining a list of each recipient's status as authorization forms are submitted regarding transfer or discharge. At the conclusion of the 30 or 60-day period (referred to under Transfer Team above), the team shall submit a report to the BHSF State Office outlining arrangements made for all recipients.

Transfer to or from Hospice

Recipients residing in an ICF/IID can receive hospice services while residing in the ICF/IID. However, the ICF/IID must enter into a written agreement in accordance with the provisions set forth in the Licensing Standards for Hospices (LAC 48:I.Chapter 82), under which the hospice program takes full responsibility for the professional management of the recipient's hospice care and the facility agrees to provide room and board to the individual.

Recipient Rights

Nothing in the transfer or discharge plan shall interfere with a recipient's rights. See Section 26.4 Recipient Rights for a description of a recipient's rights.

COMPLAINTS

It is the responsibility of the Department of Health (LDH) to offer protection and relief from abuse to recipients in institutions. This is a responsibility that LDH takes seriously and to that end has instituted a series of procedures to follow in reporting and preventing the abuse and neglect of recipients. The following procedures are established for receiving, evaluating, investigating, and correcting grievances concerning recipient care, and for the mandatory reporting of abuse and neglect in Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IIDs).

Applicability

Any person having knowledge of alleged abuse or neglect of a recipient or a recipient being denied care or treatment may submit a complaint, preferably in writing. Any person may submit a complaint if he/she has knowledge that a state law, standard, rule, regulation, correction order, or certification rule issued by LDH has been violated.

Duty to Report Abuse and Neglect

All incidents or allegations of abuse and/or neglect must be reported by telephone or fax within 24 hours to Bureau of Health Services Financing (BHSF)/Health Standards Section (HSS). The facility shall investigate all allegations of abuse and neglect and report results of such investigation to the HSS within the prescribed timeframe in accordance with licensing regulations. Copies of all pertinent documents shall be made available to the HSS as required and/or requested. Failure to comply with this requirement could result in a deficiency and/or imposition of a sanction. Those who must make a report of abuse and/or neglect are:

- Physicians or other allied health professionals;
- Social services personnel;
- Facility administration;
- Psychological or psychiatric treatment personnel;
- Registered Nurses;
- Licensed Practical Nurses; and
- Direct or indirect care staff who have knowledge of abuse or neglect of a resident of the facility.

Penalties for Failure to Make a Complaint

Any person who knowingly and willfully fails to report an abuse or neglect situation or files a false report shall be fined not more than $500.00 or imprisoned not more than two months or both.

Penalties for committing cruelty or negligent mistreatment to a recipient of ICF/IID services shall be fined not more than $10,000.00 or imprisoned with or without hard labor for more than 10 years, or both.

Where to Submit a Complaint

Complaints involving recipients of all ages in institutions received by LDH shall be referred to the Bureau of Health Services Financing Health Standards Section. (Refer to Appendix C for contact information.) Complaints may also be submitted to any local law enforcement agency.

Disposition of Complaints

If it has been determined that complaints involving alleged violations of any criminal law concerning an ICF/IID are valid, the investigating office of LDH shall furnish copies of the complaints for further investigation to both the Medicaid Fraud Control Unit of the Louisiana Department of Justice and the local office of the district attorney.

Substantiated Complaint

The LDH shall notify the administrator who must provide an acceptable plan of correction as specified below:

- If a situation presents a threat to the health and safety of the recipients, the ICF/IID shall be required to take immediate corrective action. LDH may certify non-compliance and initiate termination, revocation or suspension of the license, or impose sanctions.

- In all other violations, an expeditious correction, not to exceed 90 days, shall be required. If the provider is unable or unwilling to correct the violation, LDH may certify non-compliance and initiate termination, non-renewal, or impose sanctions.

In cases of abuse and/or neglect, referral for appropriate corrective action shall be made to the Medicaid Fraud Control Unit of the Attorney General's Office.

Unsubstantiated Complaint

LDH shall notify the complainant and the facility of the finding.

Repeat Violations

When violations continue to exist after the corrective action was taken, LDH may take appropriate action including decertification or revocation of the facility's license.

Follow-up Activity

Facilities with deficiencies will be scheduled for follow-up visits as soon as possible after the approved provider completion date on the plan of correction.

Results of Complaint Investigation

The results of the complaint investigation may be considered in conducting annual surveys and making certification decisions.

Informal Reconsideration

A complainant or a facility dissatisfied with LDH's response to the complaint investigation may request an informal reconsideration**.**

Retaliatory actions against complainants are prohibited. Persons aware of retaliatory action or threats in this regard should contact LDH.

Reporting of Incidents

For recipients involved in an accident or incident, an incident report shall be completed. This report shall include the name, date, time, details of accident or incident, circumstances under which it occurred, witnesses and action taken. Incident reports are an administrative tool to pinpoint problem areas and shall result in corrective action. These reports shall be made available to representatives of the U. S. Department of Health and Human Services and LDH.

Incidents or accidents involving recipients and all other pertinent information must be documented in the recipient's record.

The examples listed below are not all-inclusive, but are presented to assist facility employees in completing incident reports.

- **Suspicious Death** - Death of a recipient or on-duty employee when there is suspicion of death other than by natural causes.

- **Abuse and/or Neglect** - All incidents or allegations of abuse and/or neglect.

- **Runaways** - Runaways considered being dangerous to self or others.

- **Law Enforcement Involvement -** Arrest, incarceration, or other serious involvement of recipients with law enforcement authorities.

- **Mass Transfer -** The voluntary closing of a facility or involuntary mass transfer of recipients from a facility.

- **Violence** - Riot or other extreme violence.

- **Disasters -** Explosions, bombings, serious fires.

- **Accidents/Injuries -** Severe accidents or serious injury involving recipients or on-duty employees caused by recipients such as life threatening or possible permanent and/or causing lasting damage.

RECORD KEEPING

Retention of Records

The Intermediate Care Facility for individuals with intellectual disabilities (ICF/ IID) shall retain all such records on file as required by the Louisiana Department of Health (LDH) and shall have them available for inspection at request for six years from the date of service or until all audit exceptions are resolved, whichever period is longer.

In the case of minors, retain all records for three years after they become 18 years of age; **or** five years after the date of discharge, transfer, or death of the recipient.

Accounting Records

Accounting records must be maintained in accordance with generally accepted accounting principles as well as state and federal regulations. The accrual method of accounting is the only acceptable method for private providers.

NOTE: Purchase discounts, allowances and refunds will be recorded as a reduction of the cost to which they relate.

Each facility must maintain all accounting records, books, invoices, canceled checks, payroll records, and other documents relative to recipient care costs for a period of five years or until all audit exceptions are resolved, whichever period is longer.

All fiscal and other records pertaining to recipient care costs shall be subject at all times to inspection and audit by LDH, the legislative auditor, and auditors of appropriate federal funding agencies or their agents.

Daily Census Records

Each facility must maintain statistical information related to the daily census and/or attendance records for **all** recipients receiving care in the facility.

Employee Records

The ICF/IID shall retain written verification of hours worked by individual employees. The records may be sign-in sheets or time cards but shall indicate the date and hours worked. Records shall include all employees even those on a contractual or consultant basis.

The ICF/IID shall retain verification of each employee's criminal background check and disposition of charges, if any, communicable disease screening in accordance with the LDH-OPH guidelines, employee orientation and in-service training.

Billing Records

The ICF/IID shall maintain billing records in accordance with recognized fiscal and accounting procedures. Individual records shall be maintained for each recipient. These records shall:

- Clearly detail each charge and each payment made on behalf of the recipient;
- Be current and shall clearly reveal to whom charges were made and for whom payments were received;
- Itemize each billing entry; and
- Show the amount of each payment received and the date received.

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

Recipient Records General Requirements

An ICF/IID facility shall have written policies and procedures governing access, publication, and dissemination of information from recipient records. Recipient records are the property of the ICF/IID and must be protected from loss, damage, tampering, or use by unauthorized individuals. Records may be removed from the ICF/IID's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute.

An ICF/IID facility shall ensure confidential treatment of recipient records, including information contained in automatic data banks. The recipient's written consent, if the recipient is determined competent, shall be required for the release of information to any persons not otherwise authorized under law to receive it. If the recipient is not considered competent, a member of the family, responsible party or advocate shall be required to sign.

NOTE: "Blanket" signed authorizations for release of information from recipient records are prohibited.

The facility shall adhere to the criteria regarding recipient confidentiality:

- A record of all disclosures from recipient's records shall be kept.

- All staff shall be trained in the policies regarding confidentiality during orientation and in subsequent on-the-job and in-service training.

- Any information concerning a recipient or family considered confidential for general knowledge by the ICF/IID staff shall be kept in a separate file by the chief executive officer, his designee, or social worker. A notation regarding the location of this information shall be made in the recipient's record.

The ICF/IID shall make necessary records available to appropriate state and federal personnel upon request.

Records Service System

The ICF/IID shall maintain an organized central record service for collecting and releasing recipient information in such a fashion as to protect the legal rights of the recipients, ICF/IID, and ICF/IID staff.

Copies of appropriate information shall be available in the recipient living units. There must also be a written policy regarding a "charge out system" by which a recipient's record may be located when it is out of file.

The ICF/IID shall maintain a master alphabetical index of all recipients.

General Contents of Records

A written record shall be maintained for each recipient and shall:

- Be adequate for planning and for continuously evaluating each recipient's habilitation plan and providing documentation of each recipient's response to and progress made in the habilitation plan.

- Contain sufficient information to allow staff members to execute, monitor and evaluate each recipient's habilitation program.

Specifics Regarding Entries into Recipient Records

The ICF/IID shall maintain a roster of signatures, initials and identification of individuals making entries in each record. All entries in recipient records shall be:

- Legible, signed, and dated by the person making the entry;

- All corrections must be initialed and completed in such a manner that the original entry remains legible (no white out); and

- Dated **only** on the date when they are made.

Components of Recipient Records

Components of recipient records shall include, but shall not be limited to, the following:

- Admission records;

- Personal property records;

- Financial records; and

- Medical records. This includes:

    - Records of all treatments, drugs, and services for which vendor payments have been made, or which are to be made, under the Medical Assistance Program; and

    - Authorization for and the date of administration of such treatment, drugs, or services.

      NOTE: The ICF/IID shall provide sufficient documentation to enable LDH to verify that each charge is due and proper prior to payment.

- All other records that LDH finds necessary to determine an ICF/IID's compliance with any federal or state law, rule or regulation promulgated by the LDH

Interdicted Recipient

If the ICF/IID recipient has been interdicted, a copy of the legal documents shall be contained in the recipient's records.

Recipient Admission Records

Time of Admission

At the time of admission to the ICF/IID information shall be entered into the recipient's record which shall identify and give a history of the recipient. This identifying information shall at least include the following:

- A recent photograph;
- Full name;
- Sex;
- Date of birth;
- Ethnic group;
- Birthplace;
- Height;
- Weight;
- Color of hair and eyes;
- Identifying marks;
- Home address, including street address, city, parish and state;
- Social security number;
- Medical assistance identification number;
- Medicare claim number, if applicable;
- Citizenship;
- Marital status;
- Religious preference;
- Language spoken or understood;
- Dates of service in the United States Armed Forces, if applicable;
- Legal competency status if other than competent;
- Sources of support: Social Security, Veterans benefits, etc.;

- Father's name, birthplace, social security number, current address, and current phone number;
- Mother's maiden name, birthplace, social security number, current address, and current phone number;
- Name, address, and phone number of next of kin, legal guardian, or other responsible party;
- Date of admission;
- Name, address and telephone number of referral agency or hospital;
- Reason for admission;
- Admitting diagnosis;
- Current diagnosis, including primary and secondary DSM III diagnosis, if applicable;
- Medical information, such as allergies and general health conditions;
- Legal status at time of admission;
- Personal attending physician and alternate, if applicable;
- Choice of other service providers;
- Name of funeral home, if appropriate; and
- Any other useful identifying information (Refer to Section 26.1 Admission Process).

First Month after Admission

Within 30 calendar days after a recipient's admission, the following shall be completed and updated:

- A review and update of the pre-admission evaluation;
- A prognosis for programming and placement; and

- A comprehensive evaluation and an individual habilitation plan (IHP) for the recipient which includes a 24-hour schedule.

Entries in Recipient Records

The following information shall be added to each recipient's record during his/her stay at the ICF/IID:

- Reports of accidents, seizures, illnesses, and treatments for these conditions;
- Records of immunizations;
- Behavior incidents and plans to manage inappropriate behavior;
- Records of all periods where restraints were used, with justification and authorization for each, and records of monitoring in accordance with these standards;
- Reports of at least an annual review and evaluation of the recipient’s program, developmental progress, and status, as required in these standards;
- Records of visits and contacts with family and other persons;
- Records of attendance, absences, and visits away from the ICF/IID;
- Correspondence pertaining to the recipient;
- Periodic updates of the admission information (such updating shall be performed in accordance with the written policy of the ICF/IID) at least annually; and
- Appropriate authorizations and consents.

Entries at Discharge

At the time of a recipient's discharge, professional staff, as appropriate, shall enter a discharge summary into the recipient's record. This summary shall address the findings, events, and progress of the recipient while at the ICF/IID and a diagnosis, prognosis, and recommendations for future programming.

Medical Records

The ICF/IID shall maintain medical records that include clinical, medical, and psycho-social information on each recipient.

Components of Medical Records

Each recipient's record shall consist of a current active medical section and the ICF/IID's medical files or folders.

Active Medical Section

The active medical section shall contain the following information:

- Physician certification of the recipients' need for admission to the ICF/IID;
- Six months of current pertinent information relating to the active on-going medical care;
- Physician re-certification that the recipient continues to require the services of the ICF/IID;
- Nurses quarterly physical assessment;
- Pharmacy consultant's quarterly review of all medication administered to each recipient; and
- Certification that each IHP has been periodically reviewed and revised.

As the active medical section becomes bulky, the outdated information shall be periodically removed and filed in the ICF/IID's medical files.

Recipient Personal Property Records

The ICF/IID shall permit recipients to maintain and use their personal property. The number of personal possessions may be limited only for health and safety reasons. When such limitations are imposed, documentation is required in the recipient's records.

Within 24 hours after admission, the ICF/IID shall prepare a written inventory of the personal property a recipient brings to the ICF/IID. The authorized representative shall sign and retain the written inventory and shall give a copy to the recipient, family or responsible party. The written

inventory shall be revised to show if acquired property is lost, destroyed, damaged, replaced or supplemented.

Recipient Financial Records

Recipients have the right to maintain their personal funds or to designate someone to assume this responsibility for them. Recipients' income may be from Social Security, Supplemental Security Income (SSI), optional State Supplementation, other sources (VA or insurance benefits, etc.) or earnings of the recipient. A portion of the recipients' income is used to pay the recipients' share (liability) of the monthly charges for the ICF/IID. The ICF/IID shall:

- Have written policies and procedures for protecting recipients' funds and for counseling recipients concerning the use of their funds;

- Develop written procedures for the recording and accounting of recipient's personal funds;

  NOTE: ICF/IIDs shall ensure the soundness and accuracy of the recipient fund account system.

- Train recipients to manage as many of their financial affairs as they are capable; (Documentation **must** support that training was provided and the results of that training);

- Maintain current records that include the name of the person (recipient or person designated) handling each recipient's personal funds;

- Be responsible for the disbursements, deposits, soundness, and accuracy of the recipients' personal funds account. (Arrangements should be made with a federal or state insured banking institution to provide banking services for the recipients).

  NOTE: All bank charges, including charges for ordering checks, shall be paid by the ICF/IID and *not* charged to the recipient's personal funds account(s);

- Maintain current, written individual ledger sheet records of all financial transactions involving recipients' personal funds, which the facility is holding and safeguarding; and

- Make personal fund account records available upon request to the recipient, family, responsible party, and LDH.

Components Necessary for a Recipient Fund Account System

The ICF/IID shall maintain current, written individual records of all financial transactions involving recipients' personal funds for which the ICF/IID is responsible. This individual recipient participation file shall contain a ledger sheet which includes all transactions pertinent to each recipient's account, and includes the following:

- Name of the recipient and date of admission.
- Deposits which include the:
  - Date;
  - Source; and
  - Amount.
- Withdrawals which include the:
  - Date;
  - Amount;
  - Check/petty cash voucher number;
  - Payee (if check is issued); and
  - Purpose of withdrawal.
- Fund balance after each transaction.

  NOTE: Checks shall not be payable to "cash" or employees of the facility.

Receipts or invoices for disbursements shall include the following:

- Date;
- Amount of the disbursement**;**
- Description of items purchased;
- Signature of the recipient, family, or responsible party to support receipt of items;
- Supporting documentation for each withdrawal as follows:
  - Cash register receipt with canceled check or petty cash voucher signed by the recipient;
  - Invoices with canceled check or petty cash voucher signed by the recipient;

- Petty cash voucher signed by the recipient; or
- Canceled check.

NOTE: Canceled checks written to family members or responsible parties are sufficient receipts for disbursements if coupled with information regarding the purpose of the expenditures.

Supporting documentation for each deposit shall include the following:

- Receipts for all cash received on behalf of the recipients;
- Copies of all checks received on behalf of the recipients; and
- Monies either spent on behalf of the recipient or withdrawn by the recipient, family, or responsible party shall be supported on the individual ledger sheet by a receipt, invoice, canceled check or signed voucher on file.

NOTE: It is highly recommended that the functions for actual disbursement of cash and reconciling of the cash disbursement record be performed by separate individuals.

The file shall be available to the recipient, family, or other responsible party upon request during the normal administrative work day.

Recipient Personal Funds Bank Account(s)

ICF/IIDs may deposit recipient's money in individual or collective bank account(s), which shall:

- Be separate and distinct from all ICF/IID facility accounts;
- Consist solely of recipient's money and shall not be commingled with the ICF/IID facility account(s);
- Be available daily upon request during banking hours; and
- Be maintained at the facility.

Reconciliations of Recipient's Personal Funds Account(s)

There shall be a written reconciliation, at least monthly, by someone other than the custodian of the recipient's personal funds account(s). "Assets" (cash in bank, both checking and savings) must equal "liabilities" (ledger sheet balance(s). Collective bank accounts shall be reconciled to

the total of recipient's ledger sheet balances. The reconciliation shall be reviewed and approved by someone other than the preparer or custodian of the recipients' personal funds account.

Unallowable Charges to Recipient's Personal Funds Account(s)

It is the State's intent that ICF/IIDs provide total maintenance for recipients. The recipients' personal funds should be set aside for their individual wants and be spent as the recipient sees fit. In the event that a recipient desires to purchase a certain brand item, he/she has the right to do so. However, the recipient must be made aware of what the facility is providing prior to his/her making that decision. Written documentation must be maintained to support that the recipient was made aware of products or services the facility is obligated to provide.

Listed below (but not limited to) are items that **shall not** be charged to a recipient's personal funds account(s), the recipient's family or responsible party(s):

- Clothing – if a recipient does not have adequate seasonal clothing (including shoes, etc.), it is the responsibility of the facility to provide the clothing;
- Personal hygiene items;
- Haircuts;
- Dentures/braces, etc.;
- Eyeglasses;
- Hearing and other communication aids;
- Support braces;
- Any other devices identified by the interdisciplinary team;
- Wheelchairs;
- Repair and maintenance of dentures/braces, eyeglasses, hearing and other communication aids, support braces, wheelchairs or any other device identified by the interdisciplinary team;
- Transportation;
- Prescription or over-the-counter drugs;

- Recreational costs included in the IHP;
- Medical expenses of any nature;
- Tips, gifts, expenses for staff;
- Supplies or items to meet goals of IHP; and
- Damage to facility property or the recipient's possessions**.**

NOTE: The recipient may not be charged for damage to facility property or the property of others caused by that individual's destructive behavior. ICF/IIDs have a general responsibility to maintain the environment as a cost of doing business. Property of recipients damaged or stolen by others must be replaced by the facility.

Cash On Hand

ICF/IIDs shall have a minimum of cash on hand to meet recipients' spending needs. Cash on hand shall be maintained on an imprest petty cash system that includes pre-numbered petty cash vouchers. Petty cash shall be maintained at the facility and shall be available to the recipients 24 hours a day, 7 days a week.

The facility shall provide the funds to implement the petty cash system and replenish it, as necessary, from the recipients' personal funds through the use of signed vouchers. Vouchers may be signed by recipients, families, or responsible parties. When recipients cannot sign their name, vouchers shall be signed by two witnesses. Checks issued to replenish the fund should be made payable to "Custodian of Petty Cash." When funds are withdrawn from the recipients' savings account to cover signed vouchers, a receipt signed by the custodian of petty cash shall be maintained in lieu of a canceled check.

There shall be at least a weekly written reconciliation by someone other than the custodian of the petty cash fund. This reconciliation shall be reviewed and approved by someone other than the preparer or custodian of the petty cash fund.

NOTE: The facility is responsible for any shortage in the petty cash fund.

Access to Funds

Recipients shall have access to their funds during hours comparable to those of banking institutions in their local community. Large ICF/IIDs shall post the times when recipients shall have access to their funds.

Closing a Discharged Recipient's Fund Account

When a recipient is discharged, the ICF/IID shall refund the balance of a recipient's personal fund account and that portion of any advance payment not applied directly to the ICF/IID fee. The amount shall be refunded to the recipient, family or other responsible party within 30 days following the date of discharge. Date, check number, and "to close account" should be noted on the ledger sheet. When the facility is the payee for a Social Security check or other third party payments, the change in payee should be initiated immediately by the facility upon knowledge of the discharge.

NOTE: The facility shall allow the recipient to withdraw a minimum of $25.00 from his/her personal funds account on the day of discharge.

Disposition of a Deceased Recipient's Personal Funds

Upon a recipient's death, an ICF/IID shall submit written notification within 10 business days to the next of kin disclosing the amount of funds in the deceased's account as of the date of death. The ICF/IID shall hold the funds until one of the following occurs:

- **Succession Judicially Opened with Appointment or Confirmation of Succession Representative**

  If the recipient's succession is judicially opened (that is, if legal proceedings are filed in court to effect the transfer of the recipient's property to his/her heirs) and a succession representative (executor or administrator) is appointed or confirmed, the ICF/IID shall pay the funds to the succession representative upon receipt of a certified copy of the letters testamentary or letters of administration issued by the court to the representative.

- **Succession Judicially Opened Without Appointment or Confirmation of Succession Representative (Succession Opened by Affidavit in Accordance with Articles 3431-3434 of the Louisiana Code of Civil Procedure)**

  If the procedure set forth in Articles 3431-3434 of the Louisiana Code of Civil Procedure (see explanation below) is used for the recipient's succession, the ICF/IID shall pay the funds in accordance with the affidavit executed by the heirs upon receipt of a multiple original of the affidavit endorsed by Louisiana's inheritance tax collector.

  Explanation: Articles 3431-3434 of the Louisiana Code of Civil Procedure provide for a special procedure which may be used if:

- The deceased leaves property in Louisiana having a gross value of $50,000 or less;
- The deceased leaves no immovable property; and
- All of the heirs are either descendants, ascendants, brothers or sisters (or descendants thereof), or the surviving spouse.

Under this procedure, the heirs of the deceased execute an affidavit containing certain required information and submit it to Louisiana's inheritance tax collector. A multiple original of that affidavit, endorsed by the inheritance tax collector, is full and sufficient authority for payment of any money or property of the deceased to the heirs.

If within three months after the recipient's death the ICF/IID has not received a certified copy of letters testamentary or letters of administration, a certified copy of a judgment of possession, or a certified copy of an endorsed affidavit, the ICF/IID shall give notice to the secretary of the Department of Revenue and Taxation, Unclaimed Property Section, including detailed information about the recipient, his/her next of kin, and the amount of funds.

The facility shall continue to retain the funds until a court order specifies that the funds are to be turned over to the secretary of the Department of Revenue. If no order or judgment is forthcoming, the ICF/IID shall retain the funds for five years after date of death. After five years, the ICF/IID is responsible for delivering the unclaimed funds to the secretary of Revenue. A termination date of the account and the reason for termination shall be recorded on the recipient's participation file. A notation shall read, "to close account." Then endorse canceled check with check number noted on the ledger sheet shall serve as sufficient receipt and documentation.

Where the legislature has enacted a law governing the disposition of personal funds belonging to residents of state developmental centers for the mentally retarded or developmentally disabled, that law shall be applicable.

INCOME CONSIDERATION IN DETERMINING PAYMENT

Recipients Receiving Care under Title XIX

The Louisiana Department of Health (LDH)/Bureau of Health Services Financing (BHSF) Medicaid Eligibility Section determines the recipient's applicable income (liability) when computing the Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IID's) vendor payments. Vendor payments are subject to the following conditions:

- Vendor payments will begin with the first day the recipient is determined to be categorically and medically eligible or the date of admission, whichever is later.
- Vendor payment will be made for the number of eligible days as determined by the ICF/IID per diem rate less the recipient's per diem applicable income.
- If a recipient transfers from one facility to another, the vendor payment to each facility will be calculated by multiplying the number of eligible days times the ICF/IID per diem rate less the recipient’s liability.

Recipient Personal Care Allowance

The ICF/IID will not require that any part of a recipient's personal care allowance be paid as part of the ICF/IID's fee. Personal care allowance is an amount set apart from a recipient's available income to be used by the recipient for his/her personal use. The amount is determined by LDH.

Payment Policy and Limitations

Temporary Absence of the Recipient

A recipient's temporary absence from an ICF/IID will not interrupt the monthly vendor payment provided a bed is kept available for the recipient’s return, and the absence is for one of the following reasons:

- Hospitalization, which does not exceed seven days per hospitalization; or
- Leave of Absence.

Hospitalization

The reimbursement for hospital leave days is 75 percent of the applicable ICF/IID per diem rate.

Leave of Absence

A leave of absence is a temporary stay outside the ICF/IID provided for in the recipient's IHP. A leave of absence will not exceed 45 days per fiscal year (July 1 through June 30), and will not exceed 30 consecutive days in any single occurrence.

Certain leaves of absence will be excluded from the annual 45-day limit as long as the leave does not exceed the 30 consecutive day limit and is included in the written IHP. These exceptions are as follows:

- Special Olympics;
- Official state holidays;
- Road Runners Club of America events, including but not limited to events intended to raise money to help ICF/IID recipients participate in the Special Olympics;
- Louisiana planned conferences such as, but not limited to, those sponsored by the Community Residential Services Association (CRSA) a consumer driven support system that advocates choices for persons with disabilities;
- Trial discharge leaves-fourteen days per occurrence (must be in the plan of care); and
- Two days for bereavement of close family members as outlined below:
    - Parent;
    - Stepparent;
    - Stepsister;
    - Stepbrother;
    - Child;
    - Stepchild;
    - Grandchild;
    - Grandparent;

- Spouse;
- Mother-in-law;
- Father-in-law;
- Brother; and
- Sister.

The ICF/IID shall **promptly notify** LDH of absences beyond the applicable 30 or seven-day hospital limitations. Payment to the ICF/IID shall be terminated from the 31st or the 8th day, depending upon the type of absence. **Payment will commence after the individual has been determined eligible for Medicaid benefits and has remained in the ICF/IID for 30 consecutive days.**

NOTE: Elopements and unauthorized absences count against allowable leave days. However, Title XIX eligibility is not affected if the absence does not exceed 30 days and if the ICF/IID has not discharged the recipient.

The period of absence shall be determined by counting the first day of absence as the day on which the first 24-hour time period is used.

Only a period of 24 continuous hours or more shall be considered an absence. Likewise, a temporary leave of absence for hospitalization or a home visit is broken only if the recipient returns to the ICF/IID for 24 hours or longer.

Upon admission, a recipient must remain in the ICF/IID at least 24 continuous hours in order for the ICF/IID to submit a payment claim for a day of service or reserve a bed. A recipient admitted to an ICF/IID in the morning and transferred to the hospital that afternoon would not be eligible for any vendor payment for ICF/IID services.

Examples in Calculating Leave Days

The following are examples in how to calculate leave days:

Reason for Leave	Left Facility	Returned to Facility	How Leave is Reported	
Hospital or Home Leave	Jan 3rd at 9:00 am	Jan 10th at **8:00** am	Jan 4th – Jan **9th**	Leave days
Hospital or Home Leave	Jan 3rd at 9:00 am	Jan 10th at **10:00** am	Jan 4th – Jan **10th**	Leave days
Hospital	Jan 3rd at 9:00 am	Jan 21st at **8:00** am	Jan 4th – Jan 10th	Leave days
			Jan 11th – Jan **20th**	Paid or unpaid bed hold days
Hospital	Jan 3rd at 9:00 am	Jan 21st at **10:00** am	Jan 4th – Jan 10th	Leave days
			Jan 11th – Jan **21st**	Paid or unpaid bed hold days
Home Leave with State Holiday	July 3rd at 9:00 am	July 5th at **8:00** am	No Home Leave Reported	
Home Leave with State Holiday*	July 3rd at 9:00 am	July 5th at **1:00** pm	July 5th	Home Leave Day

*Do not report official or declared state holidays as home leave on the claim form. However, this should be noted in the recipient's record.

Paid bed hold days are claimed when payment is received from the recipient or family for leave days over the LDH allowable leave days, or payment is received for a non-Medicaid resident when the resident is not in the facility.

Unpaid bed hold days are claimed when no payment is received, but the facility is holding the bed for the recipient. Related days should not be reported on the cost report.

The limit on Title XIX payment for leave days does not mean that further leave days are prohibited when provided for in the IHP. After the payment limit is met, further leave days may be arranged between the ICF/IID and the recipient, family or responsible party. Such arrangements may include the following options:

- The ICF/IID may charge the recipient, family or responsible party an amount not to exceed the Title XIX daily rate.

- The ICF/IID may charge the recipient, family or responsible party a portion of the daily rate.

- The ICF/IID may absorb the cost into its operating costs.

If a recipient transfers from one facility to another, the unused leave days for the fiscal year also transfers. No additional leave days are allocated.

Temporary Absences Due to Evacuations

When local conditions require recipient evacuation, the following payment procedures apply:

- When recipients are evacuated for less than 24 hours, the monthly vendor payment is not interrupted.

- When staff is sent with recipients to the evacuation site, the monthly vendor payment is not interrupted.

- When recipients are evacuated to a family's or friend's home, the ICF/IID shall not submit a claim for a day of service or leave day, and the recipient's liability shall not be collected.

- When recipients go home at the family's request or on their own initiative, a leave day shall be charged.

- When recipients are admitted to the hospital for the purpose of evacuation of the ICF/IID, Medicaid payment shall not be made for hospital charges.

Evacuating and Temporary Sheltering Provisions

Certified, licensed intermediate care facilities for persons with intellectual disabilities (ICF's/IID) required to participate in an evacuation, as directed by the appropriate parish or state official, or which act as a host shelter site may be entitled to reimbursement of its documented and allowable evacuation and temporary sheltering costs.

The expense incurred must be in excess of any existing or anticipated reimbursement from any other sources, including the Federal Emergency Management Agency (FEMA) or its successor.

ICFs/IID must first apply for evacuation or sheltering reimbursement from all other sources and request that the Department apply for FEMA assistance on their behalf. This request must be submitted in writing along with expense and reimbursement documentation directly related to the evacuation or temporary sheltering of Medicaid residents to the Department.

Eligible Expenses

Eligible expenses for reimbursement must occur as a result of an evacuation and be reasonable, necessary, and proper. Eligible expenses are subject to audit at the Department's discretion and may include the following:

Evacuation expenses include expenses from the date of evacuation to the date of arrival at a temporary shelter or another ICF/IID. Evacuation expenses include:

- Resident transportation expenses during travel;
- Nursing staff expenses when accompanying residents, including:
  - Transportation; and
  - Additional direct care expenses, when a direct care expense increase of ten percent or more is documented. The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the Department; and
- Any additional allowable costs that are directly related to the evacuation and that would normally be allowed under the ICF/IID rate methodology.

Temporary Sheltering Expenses

Non-ICF/IID facility temporary sheltering expenses include expenses from the date the Medicaid residents arrive at a non-ICF/IID facility temporary shelter to the date all Medicaid residents leave the shelter. A non-ICF/IID facility temporary shelter includes both Medicare/Medicaid – licensed facilities and non-licensed facilities that are not part of a licensed ICF/IID and are not billing for the residents under the ICF/IID reimbursement methodology for any other Medicaid reimbursement system. Non-ICF/IID facility temporary sheltering expenses may include:

- Additional nursing staff expenses including:
  - Additional direct care expenses, when a direct care expense increase of ten percent or more is documented. The direct care expense increase must be

based on a comparison to the average of the previous two pay periods or period comparisons determined acceptable by the Department;

- Care-related expenses incurred in excess of care-related expenses prior to the evacuation;
- Additional medically necessary equipment such as beds and portable ventilators that are not available from the evacuating nursing facility and are rented or purchased specifically for the temporary sheltered residents in accordance with the following:
  - These expenses will be capped at a daily rental fee not to exceed the total purchase price of the item; and
  - the allowable daily rental fee will be determined by the Department; and
- Any additional allowable costs as determined by the Department and that are directly related to the temporary sheltering and that would normally be allowed under the ICF/IID reimbursement methodology.

NOTE: Reimbursement for room and board costs is not available when beneficiaries are sheltered at facilities not licensed as Medicare/Medicaid providers.

Host Temporary Sheltering Expenses

Host ICF/IID temporary sheltering expenses include expenses from the date the Medicaid residents are admitted to a licensed ICF/IID to the date all temporary sheltered Medicaid residents are discharged from the ICF/IID, not to exceed a six-month period.
The host ICF/IID shall bill for the residents under Medicaid's ICF/IID reimbursement methodology. Additional direct care expenses may be submitted when a direct care expense increase of ten percent or more is documented. The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the Department.

Payment of Eligible Expenses for Medicare and/or Medicaid Licensed Facilities

For payment purposes, total eligible Medicaid expenses will be the sum of nonresident-specific eligible expenses multiplied by the facility's Medicaid occupancy percentage plus Medicaid resident-specific expenses. If Medicaid occupancy is not easily verified using the evacuation resident listing, the Medicaid occupancy from the most recently filed cost report will be used.

Payments shall be made as quarterly lump-sum payments until all eligible expenses have been submitted and paid. Eligible expense documentation must be submitted to the Department by the end of each calendar quarter.

All eligible expenses documented and allowed will be removed from allowable expenses when the ICF/IID's Medicaid cost report is filed. These expenses will not be included in the allowable cost used to set ICF/IID reimbursement rates in future years.

Equipment purchases that are reimbursed on a rental rate may have their remaining basis included as allowable cost on future cost reports provided that the equipment is in the ICF/IID and being used. If the remaining basis requires capitalization, then depreciation will be recognized.

Payments shall remain under the upper payment limit cap for ICF/IID.

ICFs/IID may also be entitled to reimbursement in accordance with the Medicaid leave day provisions.

Admission

Medicaid payments become effective as of the admission date provided the recipient is medically certified as of that date and either of the following conditions is met:

- The recipient is eligible for Medicaid benefits in the ICF/IID (excluding the medically needy); **or**

- The recipient was in a continuous institutional living arrangement (nursing home, hospital, ICF/IID, or a combination of these institutional living arrangements) for 30 consecutive days. The recipient must also be determined financially eligible for Medical Assistance.

Continuous Stay

The continuous stay requirement is met if:

- The recipient dies during the first 30 consecutive days, or

- The stay is not interrupted by the recipient's absence from the ICF/IID when the absence is for hospitalization or leave of absence and is in the written IHP.

Discharge and Death

ICF/IIDs must comply with payment criteria:

- The recipient's applicable income is applied toward the ICF/IID fee effective with the date Medicaid payment is to begin.
- Medicaid payment is not made for the date of discharge. The recipient, family, nor responsible party is to be billed for the date of discharge.
- Medicaid payment is made for the day of recipient's death.

NOTE: The ICF/IID shall promptly notify BHSF of all admissions, deaths, and all discharges.

Advance Deposits

An advance deposit shall not be required or accepted from an individual whose Medicaid (Title XIX) eligibility has been established.

Exception: An ICF/IID may require an advance deposit for the current month only on that part of the total payment, which is the recipient's liability.

If advance deposits or payments are required from the recipient, family, or responsible party upon admission when Medicaid (Title XIX) eligibility has not been established, then such a deposit **shall be refunded or credited** to the person upon receipt of vendor payment.

Retroactive Payment

When individuals enter an ICF/IID prior to the date Medicaid (Title XIX) eligibility has been established, payment for ICF/IID services are made retroactive to the first day of eligibility after admission.

Timely Filing for Reimbursements

Vendor payments cannot be made if more than 12 months have elapsed between the month of initial services and submittal of a claim for these services. Exceptions for payments of claims over 12 months old can be made only with authorization from BHSF.

Refunds

Refunds to Recipients

When the facility receives vendor payments, it **shall** refund any fees for services collected from the recipient, family or responsible party by the end of the month in which vendor payment is received.

Advance payments for a recipient's liability (applicable income) shall be refunded promptly if he/she leaves the facility. The ICF/IID shall adhere to the following procedures for refunds.

- The proportionate amount for the remaining days of the month shall be refunded to the recipient, family, or the responsible party no later than 30 days following the date of discharge. If the recipient has not yet been certified, any fees for services collected from the recipient, family or responsible party shall be refunded by the end of the month in which vendor payment is received.

- No penalty shall be charged to the recipient, family, or responsible party even if the following circumstances surrounding the discharge occur:

    - Without prior notice;
    - Within the initial month; or
    - Within some other "minimum stay" period established by the ICF/IID.

Proof of refund of the unused portion of the applicable income shall be furnished to BHSF upon request.

Refunds to the Department

Participating ICF/IID

Billing or payment errors shall be corrected by using the appropriate adjustment void or Patient Liability (PLI) adjustment forms.

Non-Participating ICF/IID

Vendor payments made for services performed while an ICF/IID is in a non-participating status with the Medicaid Program must be refunded. The refund shall be made payable to "LDH - Medicaid Program."

Sitters

A sitter shall not be required or expected. However, recipients, families, or responsible parties may directly employ and pay sitters when indicated, subject to the following limitations:

- The use of sitters will be entirely at the recipient, family, or responsible party's discretion. However, the ICF/IID shall have the right to approve the selection of a sitter. If the ICF/IID disapproves the selection of the sitter, the ICF/IID must provide written notification to the recipient, family, and/or responsible party, and to the LDH stating the reasons for disapproval.

- Payment to sitters is the direct responsibility of the recipient, family or responsible party, unless:
  - The hospital's policy requires a sitter;
  - The attending physician requires a sitter; or
  - The IHP requires a sitter.

- Payment to sitters is the direct responsibility of the ICF/IID facility when:
  - The hospital's policy requires a sitter, and the recipient is on hospital leave days
  - The attending physician requires a sitter or
  - The IHP requires a sitter.

A sitter will be expected to abide by the ICF/IID's policies and procedures in accordance with LDH rules and regulations, including the LDH Health Standards Section, and professional ethics as applicable.

The presence of a sitter does not absolve the ICF/IID of its full responsibility for the recipient's care.

The ICF/IID is not responsible for providing a sitter if one is required while the resident is on home leave.

NOTE: Psychiatric Hospitals are excluded from this requirement.

Tips

The ICF/IID shall not permit tips for services rendered by its employees.

EMERGENCY AWARENESS

Disaster Preparedness

The Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IID) must have written procedures complete with instructions to be followed in the event of an internal or external disaster such as fire or other emergency actions that include:

- Specifications of evacuation routes and procedures;
- Instructions for the care of injuries and/or casualties (recipient and personnel) arising from such disaster;
- Procedures for the prompt transfer of records;
- Instructions regarding methods of containing fire; and
- Procedures for notifications of appropriate persons.

Employee Training

All ICF/IID employees must be trained in disaster preparedness in accordance with licensing regulations and federal certification requirements. Training must be part of employment orientation and ongoing training.

Disaster preparedness must include drills for all personnel so that each employee promptly and correctly carries out his/her specific role in the event of a disaster. The facility shall periodically rehearse these procedures for disaster preparedness. The minimum requirements shall be fire drills once each quarter for each shift for a minimum of 12 fire drills annually. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, and other natural disaster.

DECERTIFICATION

Termination of Certification of an Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IID)

An ICF/IID may voluntarily cease to participate in the Medical Assistance Program or may involuntarily be terminated from the program.

Reasons for Decertification of an ICF/IID

An ICF/IID may be decertified for the following reasons:

- The ICF/IID may voluntarily withdraw from the program for reasons of its own by having the owner and administrator submit a written notice of withdrawal to the Louisiana Department of Health (LDH) Health Standards Section at least 60 days in advance;
- A new owner may decide against participation in the program by submitting a written notice 60 days in advance to the LDH Health Standards Section;
- LDH may decertify an ICF/IID for failure to comply with Title XIX standards, thus canceling the facility's provider agreement;
- LDH may decertify an ICF/IID if deficiencies pose immediate jeopardy to the recipient's health, safety, rights, or welfare;
- The ICF/IID may allow its provider agreement to expire by submitting a written notice to LDH Health Standards Section at least 60 days in advance; or
- LDH may cancel the provider agreement if and when it is determined that the ICF/IID is in material breach of the contract.

Recertification of an Involuntarily Decertified ICF/IID

After involuntary decertification, an ICF/IID cannot participate as a licensed medical assistance provider unless the following conditions are met:

- The reasons for the decertification or nonrenewal of the contract no longer exist;

- Reasonable assurance exists that the factors causing the decertification will not recur;
- The ICF/ID demonstrates compliance with the required standards for a 60-day period prior to reinstatement in a participating status; and
- A professional medical review reports that recipients are receiving proper care and services.

In the event an ICF/DD's license is revoked or renewal is denied, (other than for cessation of business or non-operational status) any owner, officer, member, director, manager, or administrator of such ICF/DD facility may be prohibited from opening, managing, directing, operating, or owning another ICF/DD facility for a period of two years from the date of the final disposition of the revocation or denial action.

Examples of Situations Determined to Pose Immediate Jeopardy

Listed below are examples of situations that may result in death, serious injury or directly threatens the health, safety, or welfare of a recipient or other situations adversely affecting recipients that could result in sanctions. These examples are not intended to be all-inclusive. Other situations adversely affecting recipients could constitute sufficient basis for the imposition of sanctions.

Poisonous Substances

An ICF/IID fails to provide proper storage of poisonous substances.

Falls

An ICF/IID fails to maintain required direct care staffing and/or a safe environment as set forth in the regulations such as equipment not being properly maintained or personnel not responding to a recipient's request for assistance.

Assaults

An ICF/IID fails to maintain required direct care staffing and fails to take measures when it is known that a recipient is combative and assaultive to other recipients, or the ICF/IID fails to take corrective action against an employee who has a history of recipient abuse and assaults a recipient.

Physical Restraints Resulting in Permanent Injury
An ICF/IID employee improperly applies physical restraints contrary to published regulations or fails to check and release restraints as directed by regulations or physician's written instructions.

Control of Infections

An ICF/IID fails to follow or meet infection control standards as ordered in writing by the physician.

Medical Care

An ICF/IID fails to secure proper medical assistance for a recipient.

A recipient's condition declined and no physician was informed. This includes the following:

- An ICF/IID failed to follow up on unusual occurrences of negative findings;
- An ICF/IID failed to obtain information regarding appropriate care before and after a recipient's hospitalization; and
- An ICF/IID failed to timely hospitalize a recipient during a serious illness.

An ICF/IID did not follow written physician's orders. This includes failure to fill prescriptions timely.

Medications

An ICF/IID improperly stores and distributes medications. This would include the following:

- Knowingly withholding a recipient's medications;

  NOTE: The recipient does have the right to refuse medications. Such refusal *must be documented* in the recipient's record and *brought to the attention of the physician and ID team.*

- Omitting medications without justification;
- Excessive medication errors; and
- Improperly storing narcotics or other prescribed drugs, mishandling of drugs or other pharmaceutical problems.

Improper Treatments

An ICF/IID employee knowingly does the following:

- Performs treatment contrary to a physician's order;
- Fails to feed recipients who are unable to feed themselves as set forth in physician's instructions;
- Fails to obtain a physician's order for use of chemical or physical restraints; or
- Fails to check and release physical restraints as specified in state regulations.

Natural Disaster/Fire

An ICF/IID fails to train its staff members in disaster/fire procedures as required for licensing or failure to meet staffing requirements.

Decubitus Ulcers

An ICF/IID fails to follow decubitus ulcer care measures in accordance with a physician's written orders.

Elopement

An ICF/IID fails to provide necessary supervision of its recipients or take measures to prevent a recipient with a history of elopement problems from wandering away. Examples of preventative measures include, but are not limited to the following:

- Documentation that the elopement problem has been discussed with the recipient's family and the Interdisciplinary Team; and
- Personnel have been trained to make additional efforts to monitor these recipients.

Environment/Temperature

An ICF/IID fails to reasonably maintain its temperature control system as required by regulations. Isolated incidents of breakdown or power failure will not be considered immediate jeopardy.

Life Safety

An ICF/IID knowingly fails to maintain the required Life Safety code system such as:

- Properly functioning sprinklers, fire alarms, smoke sensors, fire doors, electrical wiring;
- The practice of fire or emergency evacuation plans; or
- Stairways, hallways and exits are kept free from obstruction.

Staffing

An ICF/IID consistently fails to maintain minimum staffing. Isolated incidents where the facility does not maintain staffing due to personnel calling in sick or other emergencies are excluded. However, the ICF-DD shall have policies and procedures to ensure a plan is in place for back-up staffing for the provision of sufficient care and services.

Dietary Services

An ICF/IID fails to follow the minimum dietary needs or special dietary needs as ordered by a physician. The special diets must be prepared in accordance with physician's orders or a diet manual approved by the American Dietary Association.

Sanitation

An ICF/IID fails to adhere to state and federal sanitation regulations. The following are examples of poor sanitation:

- Strong odors linked to a lack of cleanliness;
- Dirty buildup on floors and walls;
- Dirty utensils, glasses and flatware; and
- Insect or rodent infestation.

Equipment and Supplies

An ICF/IID fails to provide equipment and supplies authorized in writing by a physician as necessary for a recipient's care.

Recipient Rights

An ICF/IID violates recipients' rights and such violations result in the recipients' distress to such an extent that their psychosocial functions are impaired or such violations directly threaten their psychosocial functioning. This includes the following:

- Psychological abuse; and
- The use of corporal punishment.
- Allowance of the following responses to recipients by staff members and employment supervisors:
    - Physical exercise or repeated physical motions;
    - Excessive denial of usual services;
    - Any type of physical hitting or other painful physical contacts except as required by medical, dental, or first aid procedures necessary to preserve the recipient's life or health;
    - Requiring the recipient to take on an extremely uncomfortable position,
    - Verbal abuse, ridicule, or humiliation;
    - Requiring the recipient to remain silent for a long period of time;
    - Denial of shelter, warmth, clothing or bedding; or
    - Assignment of harsh physical work.
- Failure to afford the recipient with the opportunity to attend religious services;
- Denial of a recipient's meal without a doctor's order; and
- Failure to afford the recipient with suitable supervised opportunities for interaction with members of the opposite sex, except where a qualified professional responsible for the formulation of a particular individual's treatment/habilitation plan writes an order to the contrary and explains the reasons.

The secretary of LDH has the final authority to determine what constitutes "immediate jeopardy" or serious threat.

RATE DETERMINATION

The State Plan amendment and/or published rule are the final authority for rate setting for intermediate care facilities for the individuals with intellectual disabilities (ICF/IIDs). The authority for this rate setting system is found in LA R.S. 15: 1081-1086 and in Federal Regulations at 42 CFR 447.250 through 42 CFR 447.274.

Rate Structure

Private ICF/IID facilities are reimbursed on the Inventory for Client and Agency Planning (ICAP) rate methodology. This methodology is based on the facility's bed size and the individual's level of care. The ICAP scoring sheet is part of the admission papers reviewed by the Office for Citizens with Developmental Disabilities.

The ICAP is a standardized instrument for assessing adaptive and maladaptive behavior and includes a service score which indicates the overall level of care, supervision or training the individual requires. The ICAP utilizes the following five support levels to describe the levels of support needed for individuals with disabilities:

- Intermittent – supports on an "as needed basis." Characterized as episodic in nature, the person does not always need the support(s), or short-term supports needed during life-span transition (e.g., job loss or an acute medical crisis). Intermittent supports may be high or low intensity when provided;

- Limited – supports characterized by consistency over time, time-limited but not of an intermittent nature, may require fewer staff members and less costs than more intense levels of support (e.g., time-limited employment training or transitional supports during the school to adult provided period);

- Extensive – supports characterized by regular involvement (e.g., daily) in at least some environment (such as work or home) and not time-limited (e.g., long-term support and long-term home living support);

- Pervasive – supports characterized by their constancy, high intensity; provided across environments; and/or potential life-sustaining nature. Pervasive supports typically involve more staff members and intrusiveness than do extensive or time-limited supports; and

- Pervasive Plus – is a time-limited specific assignment to supplement required Level of Need services or staff for the provision of complex medical care (> 180 minutes

of nursing care a week) or to supplement required direct care staff (> 16 hours a week of 1:1 staff) due to extremely life threatening behavior. Requests for Pervasive Plus will be reviewed and approved by the Louisiana Department of Health (LDH) Pervasive Plus Committee.

Facilities are divided into peer groups, based on bed size. Peer groups are as follows:

- 1 – 8 beds;
- 9 – 15 beds;
- 16 – 32 beds; and
- 33 or more beds.

Resident Per Diem Rates

Resident per diem rates are calculated based on information reported on the cost report. ICF/IIDs will receive a rate for each resident. The rates are based on cost components appropriate for an economic and efficient ICF/IID providing quality service. The resident per diem rates represent the best judgment of the state to provide reasonable and adequate reimbursement required to cover the costs of economic and efficient ICF/IIDs.

Cost data used in setting base rates is from the latest available audited or desk reviewed cost reports. The initial rates are adjusted to maintain budget neutrality upon transition to the ICAP reimbursement methodology. For rate periods between rebasing, the rates are trended forward using the index factor contingent upon appropriation by the legislature.

A resident's per diem rate is the sum of the following:

- Direct care per diem rate;
- Care related per diem rate;
- Administrative and operating per diem rate;,
- Capital rate; and
- Provider fee.

Determination of Rate Components

Direct Care Per Diem Rate

The direct care per diem rate is a set percentage over the median adjusted for the acuity of the resident based on the ICAP, tier based on peer group. The direct care per diem rate is determined as follows:

- Median Cost

  The direct care per diem median cost for each ICF/IID is determined by dividing the facility's total direct care costs reported on the cost report by the facility's total days during the cost reporting period. Direct care costs for providers in each peer group are arrayed from low to high and the median (50th percentile) cost is determined for each peer group.

- Median Adjustment

  The direct care component shall be adjusted to 105 percent of the direct care per diem median cost in order to achieve reasonable access to care.

- Inflationary Factor

  These costs are trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor.

- Acuity Factor

  Each of the ICAP levels will have a corresponding acuity factor. The median cost by peer group, after adjustments, shall be further adjusted by the acuity factor (or multiplier) as follows:

ICAP Support Level	Acuity Factor (Multiplier)
Pervasive	1.35
Extensive	1.17
Limited	1.00
Intermittent	.90

- Direct Service Provider Wage Enhancement

  For dates of service on or after February 2007. The direct care reimbursement to ICD/IID providers must include a direct care service worker incentive in the amount of $2 per hour. It is the intent that this wage enhancement be paid to the direct care staff. Non-compliance with the wage enhancement shall be subject to recoupment.

  At least 75 percent of the wage enhancement must be paid to the direct support professional and 25 percent must be used to pay employer-related taxes, insurance and employee benefits.

  The wage enhancement will be added on to the current ICAP rate methodology as follows:

  - Per diem rates for recipients residing in 1-8 bed facilities will increase $16.00;
  - Per diem rates for recipients residing in 9-16 bed facilities will increase $14.93; and
  - Per diem rates for recipients residing in 16+ bed facilities will increase $8.

The direct care costs consist of all the costs related to direct care interaction with the recipient. Direct care costs include the following:

- In-house and contractual salaries;
- Benefits;
- Payroll taxes for all positions directly related to patient care;
- Worker's compensation;
- Medical services (routine, and extraordinary);
- Medical supplies;
- Therapeutic and training supplies;

- Habilitation costs;
- Recreational supplies; and
- Consultants.

Care Related Per Diem Rate

The care related per diem rate shall be a statewide price at a set percentage over the median and shall be determined as follows:

- Median cost – the care related per diem median cost for each ICF/IID is determined by dividing the facility's total care related costs reported on the cost report by the facility's actual total resident days during the cost reporting period. Care related costs for all providers are arrayed from low to high and the median (50^{th} percentile) cost is determined;
- Median Adjustment – the care related component shall be adjusted to 105 percent of the care related per diem median cost in order to achieve reasonable access to care; and
- Inflationary Factor – these costs shall be trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor.

Care related costs include the following:

- In-house and contractual salaries;
- Benefits;
- Payroll taxes;
- Supplies that help support direct care but do not directly involve caring for the patient and ensuring their well-being (e.g., dietary and educational); and
- Personal items, such as clothing and personal hygiene items.

Administrative and Operating Per Diem Rate

The administrative and operating per diem rate shall be a statewide price at a set percentage over the median, tier based on peer group. The administrative and operating component shall be determined as follows:

- Median cost – the administrative and operating per diem median cost for each ICF-IID is determined by dividing the facility's total administrative and operating costs reported on the cost report by the facility's actual total resident days during the cost reporting period. Administrative and operating costs for all providers are arrayed from low to high and the median (50^{th} percentile) cost is determined.

- Median Adjustment – the administrative and operating component shall be adjusted to 103 percent of the administrative and operating per diem median cost in order to achieve reasonable access to care.

- Inflationary Factor – these costs shall be trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor.

Administrative and operating costs include the following:

- In-house and contractual salaries;
- Benefits;
- Payroll taxes for administration and plant operation maintenance staff;
- Utilities;
- Accounting;
- Insurance;
- Maintenance staff;
- Maintenance supplies;
- Laundry and linen;
- Housekeeping; and

- Other administrative type expenditures.

Capital Per Diem Rate

The capital per diem rate shall be a statewide price at a set percentage over the median, tier based on peer group. The capital per diem rate shall be determined as follows:

- Median costs – the capital per diem median cost for each ICF/IID is determined by dividing the facility's total capital costs reported on the cost report by the facility's actual total resident days during the cost reporting period. Capital costs for providers of each peer group are arrayed from low to high and the median (50th percentile) cost is determined for each peer group.

- Median adjustment – the capital cost component shall be adjusted to 103 percent of the capital per diem median cost in order to achieve reasonable access to care.

- Inflationary factor – capital costs shall not be trended forward.

Capital costs include the following:

- Depreciation;

- Interest expense on capital assets;

- Leasing expenses;

- Property taxes; and

- Other expenses related to capital assets

Provider Fee

The provider fee shall be calculated by the department in accordance with state and federal rules. Effective April 1, 2014, the provider fee is $16.15.

A bed fee shall be paid by each ICF/IID facility for each bed utilized for the provision of care on a daily basis. ICF/IID facilities shall provide documentation quarterly of utilization for all licensed beds in conjunction with payment of the fee. Quarters are defined as:

- December through February;

- March through May;
- June through August; and
- September through November.

LDH will mail a Quarterly Fee Report to each ICF/IID before the end of the quarter. Reports of quarterly utilization and fees shall be submitted to the department and shall be due on the 20th calendar day of the month following the close of the quarter and shall be deemed delinquent on the 30th calendar day of the month. Submission of the report is mandatory regardless if no fee is due.

The rates for the 1-8 bed peer group shall be set based on costs in accordance with the direct care per diem rate, care-related per diem rate, Administrative and operating per diem rate, capital per diem rate and provider fee. The reimbursement rates for peer groups of larger facilities will also be set in accordance with the same criteria; however, the rates will be limited as follows:

- The 9-15 peer group reimbursement rates will be limited to 95 percent of the 1-8 bed peer group reimbursement rates;
- The 16-32 bed peer group reimbursement rates will be limited to 95 percent of the 9-15 bed peer group reimbursement rates; and
- The 33 and greater bed peer group reimbursement rates will be limited to 95 percent of the 16-32 bed peer group reimbursement rates.

Adjustments to the Medicaid daily rate may be made when changes occur that eventually will be recognized in updated cost report data (such as a change in the minimum wage or Federal Insurance Contributions Act (FICA) tax rates). These adjustments would be effective until such time as the data base used to calculate rates fully reflect the change. Adjustments to rates may also be made when legislative appropriations would increase or decrease the rates calculated in accordance with this rule. The LDH Secretary makes the final determination as to the amount and when adjustments to rates are warranted.

A facility requesting a pervasive plus rate supplement shall bear the burden of proof in establishing the facts and circumstances necessary to support the supplement in a format and with supporting documentation specified by the LDH ICAP Review Committee. The LDH ICAP Review Committee shall make a determination of the most appropriate staff required to provide requested supplemental services. The amount of the Pervasive Plus supplement shall be calculated using the Louisiana Civil Service pay grid for the appropriate position as determined by the LDH ICAP

Review Committee and shall be the 25th percentile salary level plus 20 percent for related benefits times the number of hours approved.

Other Recipient Specific Adjustments to the Rate

A facility may request a recipient specific rate supplement for reimbursement of the costs for enteral nutrition, ostomy or tracheotomy medical supplies or a vagus nerve stimulator. The provider must submit sufficient medical supportive documentation to the LDH ICAP Review Committee to establish medical need for enteral nutrition, ostomy or tracheotomy medical supplies. The amount of reimbursement determined by the ICAP Review Committee shall be based on the average daily cost for the provision of the medical supplies. The provider must submit annual documentation to support the need for the adjustment to the rate.

Prior authorization for implementation for the vagus nerve stimulator shall be requested after the evaluation has been completed but prior to stimulator implantation. The request to initiate implantation shall come from the multi-disciplinary team as a packet with the team's written decision regarding the recipient's candidacy for the implant and the results of all pre-operative testing. The prior authorization form for the device and surgeon shall be included in the packet forwarded to the prior authorization unit.

The amount of reimbursement shall be the established fee on the Medicaid Fee Schedule for medical equipment and supplies.

ICAP Requirements

An Inventory for Client and Agency Planning (ICAP) assessment must be completed for each recipient of ICF/IID services upon admission and while residing in an ICF/IID in accordance with departmental regulations. Providers must keep a copy of the recipient's current ICAP protocol and computer scored summary sheets in the recipient's file. If a recipient has changed ICAP service level, providers must also keep a copy of the recipient's ICAP protocol and computer scored summary sheets supporting the prior level. ICAPs must reflect the resident's current level of care.

ICAP Monitoring

ICAP scores and assessments will be subject to review by LDH and its contracted agents. The reviews of ICAP submissions include, but are not limited to the following:

- Reviews when statistically significant changes occur within an ICAP submission or submissions;

- Random selections of ICAP submissions;
- Desk reviews of a sample of ICAP submissions; and
- On-site field reviews of ICAPs.

ICAP Review Committee

The ICAP Review Committee reviews requests for the pervasive plus supplement or medical supply add-on. Pervasive plus is a time-limited specific assignment of staff to supplement the required level of need services which may include staff to provide life sustaining complex medical care (> 180 minutes of nursing care a week) or to supplement required direct care staff (>16 hours a week of 1:1 staff) due to dangerous life threatening behavior so serious that the recipient could cause serious physical injury to self or others and requires additional trained support staff to be at "arm's length" during waking hours. Medical add-on covers the average daily cost for certain medical supplies.

Providers requesting the pervasive plus supplement or medical add-on rate supplement bear the burden of proof in establishing the facts and circumstances necessary to support the request with supporting documentation specified by the ICAP Review Committee.

For providers receiving pervasive plus supplements or other client specific adjustment to the rate, the facility-wide direct care floor is established at 94 percent of the per diem direct care payment and at 100 percent of any rate supplements or add on payments received by the provider, including the pervasive plus supplement, the complex care add-on payment and other client specific adjustment to the rate. The facility-wide direct care floor will be applied to the cost reporting year in which the facility receives a pervasive plus supplement and/or client specific rate adjustment. In no case however, shall a facility receiving a pervasive plus supplement and/or client specific rate adjustment have total facility payments reduced to less than 104 percent of the total facility cost as a result of imposition of the direct care floor.

The support staff member assigned to supervise the person has no other duties during the assignment. The assignment is specific to the type of and duration of services to be provided. The assigned staff is educated and able to follow the behavior management plan. **The support member does not replace the minimum staff required for the level of care (LOC).**

The ICAP Review Committee shall represent LDH should a provider request an informal reconsideration regarding the Regional Health Standards' determination. The ICAP Review Committee shall make final determination on any ICAP level of care changes prior to the appeals process. The ICAP Review Committee shall be made up of the following:

- Director of the Health Standards Section or his/her appointee;
- Director of Rate and Audit Review Section or his/her appointee;
- Assistant Secretary for the Office for Citizens with Developmental Disabilities or his/her appointee; and
- Other persons as appointed by the secretary.

When an ICAP score is determined to be inaccurate, the department shall notify the provider and request documentation to support the level of care. If the additional information does not support the level of care, an ICAP rate adjustment will be made to the appropriate ICAP level effective the first day of the month following the determination.

Facility Direct Care Staffing Requirements

There must be a responsible direct care staff on duty and awake on a 24 hour basis (when recipients are present) to take prompt, appropriate action in case of injury, illness, fire or other emergency.

There must be sufficient direct care staff to manage and supervise recipients in accordance with their individual program plans. Direct care staff is defined as present on-duty staff calculated over all shifts in a 24-hour period for each defined residential unit. Minimum staffing ratios of direct care staff to recipient does not include any 1:1 staff provided for under Pervasive Plus assignments. Pervasive Plus assignments are in addition to minimum staffing requirements.

Complex Care

Effective for dates of service on or after October 1, 2014, non-state intermediated care facilities for individuals with intellectual disabilities (ICF/IID), may receive an add-on payment to the per diem rate for providing complex medical care to Medicaid recipients who require such services. The add-on rate adjustment shall be a flat fee amount and may consist of payment for any of the following components:

- Equipment only (only Medicaid allowable equipment);
- Direct service worker (DSW);
- Nursing only;
- Equipment and DSW;

- DSW and nursing;
- Nursing and equipment; or
- DSW, nursing and equipment.

Non-State owned ICFs/IID, may qualify for an add-on rate for recipients meeting documented major_medical or behavioral complex care criteria. This must be documented on the complex support need screening tool provided by the Department. All medical documentation indicated by the screening tool form and any additional documentation requested by the Department must be provided to qualify for the add-on payment. Documentation must be recent within the last year.

The complex support need screening tool shall be completed and submitted to the Department annually from the date of initial approval of each add-on payment. This annual submittal shall be accompanied by all medical documentation indicated by the screening tool form and any additional documentation requested by the Department. It is the provider's responsibility to submit for renewals annually.

In order to meet the complex care criteria, the presence of a significant medical or behavioral health need must exist and be documented. This must include:

- Endorsement of at least one qualifying condition with supporting documentation; and
- Endorsement of symptom severity in the appropriate category based on qualifying condition(s) with supporting documentation.

Qualifying conditions for complex care must include at least one of the following as documented on the complex support need screening tool:

- Significant physical and nutritional needs requiring full assistance with nutrition, mobility and activities of daily living;
- Complex medical needs/medically fragile; or
- Complex behavioral/mental health needs.

Enhanced supports must be already being provided and verified with supporting documentation to qualify for the add-on payments. Additional criteria and information is found in the Louisiana Administrative Code (LAC) 50: VII, §32915.

Complex Care packets are received and reviewed by the complex care team. All packets are initially submitted to the complex care team coordinator. If the information is received in its entirety and reviewed by the complex care team prior to the 15th of the month, the rate will be approved retroactively to the 1st of the month in which it was submitted.

If the information is received in its entirety and reviewed after the 15th of the month, the rate will be effective the first day of the next month. This is done to reduce billing errors and to encourage complete information submissions. Only recent relative information is considered when determining the appropriate add-on rate.

Providers receiving complex care add-on rates will be required to meet the direct care floor at 85 percent of the direct care component of the rate and 100 percent of the add-on amount. This is applied facility wide and within the cost report year the complex care add-on is received.

If a facility is receiving both the complex care add-on and pervasive plus add-on in the same facility, then the direct care floor is facility-wide at 94 percent of the direct care component of the rate and 100 percent of the add-on amounts.

Determinations for pervasive plus or complex care add-on rates will be made in accordance with what is best for the recipient and what the recipient needs or would best benefit from. If it is determined the recipient would best be served with 1:1 supports under the pervasive plus supplement, the provider will be offered this option. If the provider refuses, then complex care is not an alternative as the two add-on rates serve different purposes.

Transfer of Recipients with Add-On Rates

If a recipient is receiving an add-on payment for pervasive plus, complex care or other specific adjustment to the rate, and transfers to a new provider, the transferring provider must notify the ICAP coordinator of the transfer. The new provider has the responsibility of notifying the Department if they do not want to continue with the add-on payment. This notification must be in writing and submitted to the Complex Care team coordinator and/or ICAP coordinator within seven days of receiving the new transfer. Failure of the new provider to notify the Department will result in the facility being required to meet the facility-wide direct care floor without further notification from the Department.

Minimum Ratios of Direct Care Staff to Recipients:

Description	Staff to Recipient Ratio
For each defined residential living unit serving: • Children under the 12 years of age; • Severely and profoundly retarded recipients; • Recipients with severe physical disabilities; • Recipients who are aggressive, assaulting or security risks; or • Recipients who manifest severely hyperactive or psychotic-like behavior.	**1 to 3.2**
For each defined residential living unit serving moderately regarded recipients	**1 to 4**
For each defined residential living unit serving recipients who function within the range of mild retardation	**1 to 6.4**

Minimum Direct Care Staffing Patterns (Based on Federal Requirements)

Facilities with 8 beds or less				
	Intermittent	**Limited**	**Exclusive**	**Pervasive**
Day	1:5	1:4	1:3	1:2
Eve	1:5	1:4	1:3	1:2
Night	1:6	1:6	1:6	1:6

Facilities with 9-13 beds				
	Intermittent	**Limited**	**Exclusive**	**Pervasive**
Day	1:5	1:4	1:3	1:2.5
Eve	1:5	1:4	1:3	1:2.5
Night	1:10	1:10	1:10	1:7.5
Facilities with 14 beds or more				
	Intermittent	**Limited**	**Exclusive**	**Pervasive**
Day	1:7	1:7	1:5	1:3
Eve	1:7	1:6	1:5	1:3
Night	1:20	1:20	1:20	1:20

COST REPORTS

Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IID) providers are required to file annual cost reports to the Louisiana Department of Health (LDH) in accordance with instructions as follows:

- Each ICF/IID is required to report all reasonable and allowable costs on a regular facility cost report including any supplemental schedules designated by LDH.

- Separate cost reports must be submitted by central/home office(s) and habilitation programs when costs of those entities are reported on the facility cost report.

Cost reports must be prepared in accordance with cost reporting instructions adopted by the Bureau of Health Services Financing (BHSF) using definitions of allowable and non-allowable cost contained in the *Medicare Provider Reimbursement Manual* (HIM-15) unless other definitions of allowable and non-allowable cost are adopted by BHSF.

Each provider must submit an annual cost report for fiscal year ending June 30. The cost reports must be filed within 90 days after the state's fiscal year ends.

Exceptions

Limited exceptions for extensions to the cost report filing requirements will be considered on an individual facility basis upon written request by the provider to the Medicaid director or designee. Providers must attach a statement describing fully the nature of the exception request. The extension must be requested by the normal due date of the cost report.

Direct Care Floor

A facility wide direct care floor may be enforced upon deficiencies related to direct care staffing requirements cited during the Health Standards Section annual survey or during a complaint investigation in accordance with LAC 50:I.5501, et seq. The floor shall be applied in the cost report year of the violation.

For providers receiving pervasive plus supplements and other recipient specific adjustments to the rate in accordance with Section 26.11 – Other Recipient Specific Adjustments to the Rate, the facility wide direct care floor is established at 94 percent of the per diem direct care payment, the pervasive plus supplement, and other recipient specific adjustments to the rate. The direct care floor will be applied to the cost reporting year in which the facility receives a pervasive plus supplement and/or a recipient specific rate adjustment.

In no case, however, shall a facility receiving a pervasive plus supplement and/or recipient specific rate adjustment have total facility payments reduced to less than 104 percent of the total facility cost as a result of imposition of the direct care floor.

For facilities for which the direct care floor applies, if the direct care cost the facility incurred on a per diem basis is less than the appropriate facility direct care floor, the facility shall remit to BHSF the difference between these two amounts times the number of facility Medicaid days paid during the cost reporting period. This remittance shall be payable to BHSF upon submission of the cost report.

Upon completion of desk reviews or audits, facilities will be notified by BHSF of any changes in amounts due based on audit or desk review adjustments.

All costs submitted on cost reports must be recipient care related. 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 provider contract contains a penalty provision for cost reports with all forms completed, not received on a timely basis. (See Section 26.14 – Sanctions and Appeals for additional information regarding sanctions)

Providers are required to maintain adequate financial records and statistical data for proper determination of reimbursable costs. All ICF/IID providers receiving Medicaid funding will maintain, for five years following submission of the cost report, all financial and statistical information necessary to substantiate cost data. Providers are required to make these records available upon request to representatives of LDH the State of Louisiana, or the United States Department of Health and Human Services (DHHS).

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, basis 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. The census records must include totals for each resident for each month and also must reflect monthly totals by payor-type. Census days must be segregated between Medicaid and other payors. All census occurrences must be reflected on the census document. Supporting documentation for admission, discharges, death, hospital and home leaves must be maintained and should include dates and times.

Each facility receiving funds from other public sources must report such on the cost report form, even if the funding is provided for other programs, and make available additional information on this funding as requested by LDH

The data submitted on the cost report will reflect Balance Sheet and Income Statement information for the twelve-month period being submitted. Cost data will be appropriately adjusted for rate setting purposes.

All costs submitted on cost reports must be care related. A knowing inclusion of costs in violation of this requirement, as well as other requirements of the HIM-15, could subject the provider to criminal prosecution under La. R. S. 14:70.1 or La. R. S. 14:133.

For allocated or shared costs, a separate cost report must be completed showing the total costs prior to allocation. The method of allocation and the percentage of allocation to each individual provider must also be shown.

Providers are required to submit the following documents with their cost report submission:

- Cost Report;
- Detailed fixed asset depreciation schedule;
- Copies of leases;
- Working Trial Balance; and
- Central office and habilitation schedules.

Cost Report Adjustments

The following guidelines are provided to aid in determining allowable and non-allowable costs for rate setting and cost reporting purposes. Allowable costs generally require no adjustment when reported. Non-allowable costs should be reflected as such by an adjustment to the proper cost category on the cost report schedule.

Salaries

Salaries are an allowable cost if:

- The number of employees is based upon individual facility requirements determined in conjunction with LDH Licensing and Certification and the appropriate program office;
- Functions performed are related to the provision of care in the facility; and

- Individual salaries do not exceed the maximum allowable under Louisiana State Civil Service Salary Schedules for comparable positions. The salary maximums are published periodically by LDH.

Taxes

Taxes are an allowable cost with the following specific exemptions:

- Federal income or excess profit tax;
- State income or franchise tax;
- Taxes relating to financing;
- Special assessments (this would be capitalized and amortized);
- Taxes for which exemptions are available;
- Taxes on property not related to direct recipient care; and
- Self-employment (FICA) taxes applicable to individual proprietors, partners, etc.

Advertising Costs

The following types of advertising costs are allowable:

- Classified newspaper advertising to recruit personnel or solicit bids; and
- Telephone "Yellow page" advertising, except in the event that such advertisement is promotional in nature. Allowable cost is limited to the cost of a 1" x 1" size advertisement.

Costs for fund raising, public relations and promotional advertising are income producing items which should be offset against income provided.

Bad Debts

Bad debts, charity and courtesy allowances are deductions from revenue and are not an allowable cost.

Dues

Dues are not an allowable expense with the exception of dues to one's professional organizations.

Interest Expense

Generally, necessary and proper interest on both current and capital indebtedness is an allowable cost.

"Necessary" requires that interest be:

- Incurred on a loan made to satisfy a financial need of the provider;
- Incurred on a loan reasonably related to patient care; and
- Reduced by investment income.

"Proper" requires that interest be:

- Incurred at a rate not in excess of what a prudent borrower would have to pay and
- Paid to a lender not related through control or ownership or personal relationship to the provider. Exceptions are allowable only in accordance with HIM-15, Section 218.

Attorney Fees

Only actual and reasonable attorney fees incurred for non-litigation legal services which are directly related to recipient care will be allowed. Monies paid to an attorney or a law firm as a retainer, rather than as legal fees for services actually performed, are non-allowable expenses.

Health Costs

In all of the examples of allowable expenses below, it is required that a facility will attempt to utilize public resources prior to employing or contracting with totally private medical providers or purchasing medical supplies.

Examples of public resources would include Medicaid medical providers for eligible individuals:

- State or city supported clinics and hospitals for immunizations;

- Examinations and other screening services;
- Emergency treatment; and
- On-going special treatment needs such as:
    - Handicapped Children's Program for orthopedic problems;
    - Charity Hospital system for dialysis needs;
    - Mental health clinics for counseling and medication;
    - Local education agencies for evaluation;
    - Physical therapy;
    - Occupational therapy and speech therapy services for individuals under age 22; and
    - Local civic organizations for glasses, wheelchairs, etc.

Medical services provided by the facility that may be included for cost reporting purposes if documented that these services are not available by Title XIX providers or other public resources include:

- Periodic medical examinations that include vision, hearing, and routine screening and laboratory examinations as determined necessary by the physician;
- Immunization;
- Tuberculosis control;
- Physician services, minimally to supervise the general health conditions and practices of the facility and be available for emergencies on a 24-hour, seven days a week basis;
- Initial and periodic dental examinations and routine treatment, including provisions for emergency treatment at all times;
- Dental hygiene program;
- Psychological testing and counseling when provided routinely to all recipients;
- Psychiatric examination and treatment when provided routinely for facility recipients; and

- Medical appliance upkeep, repairs, and purchase of medical supplies for the general facility population.

The cost for the above services will be limited to that which is considered reasonable not to exceed the Medicaid payment where applicable.

Income Producing Expenses

Any income from such items as sale of medical records, sale of scrap and waste, rental of space, etc. (when the item was included as an allowable cost) shall be offset. Purchase discounts, allowances, and refunds will be recorded as a reduction of the cost to which they relate.

Transportation Costs

Allowable costs include transportation intrinsic to the well-being of the recipient, including but not limited to visits with relatives, prospective foster or adoptive parents, and other activities or events that are an integral part of the 24-hour program and not available through another resource. Expenses for an attendant, when required, may be allowed if not already charged to the State's program under Titles XIX, XX, IV-B, or other publicly funded programs.

Other Non-Allowable Expenses

The following is a list of other non-allowable expenses:

- Appraisal costs;
- Capital expenditures;
- Collection costs;
- Payments to directors on the facility's Board of Directors. This does not include reimbursement for expenses;
- Educational costs;
- Fines, penalties, judgments or settlements of any kind;
- Any costs not related to care in the facility;
- Payments made by the facility as gifts, assessments or paybacks to parent organizations;

- Expenses reimbursable by other State or Federally funded programs;
- Vending machine expenses;
- Expenses for gifts, flower and coffee shops; and
- Depreciation of equipment used to secure self-generated revenue

Start-up Costs

In the period of developing a facility's ability to furnish recipient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to recipient care services rendered after the time of preparation, they may be capitalized as deferred charges and amortized. Start-up costs include allowable costs incident to the start-up period. Costs that are properly identifiable as organization costs or capitalized as construction costs must be appropriately classified as such and excluded from start-up costs.

Start-up costs are amortized over a period of 60 months, beginning from the month of first admission of a recipient.

Depreciation

An appropriate allowance for depreciation on buildings and equipment related directly to recipient care services is an allowable cost. Depreciation must be computed by the straight-line method only. The estimated useful life of fixed assets will be based on the American Hospital Association's "Estimated Useful Lives of Depreciation Hospital Assets" according to the HIM-15, Part I, Section §104.17.

Facilities must maintain adequate records to determine cost, value, and reasonable useful life of buildings and equipment. Assets must be capitalized if cost is at least $5,000 and if they have a useful life of at least two years.

For depreciation expense to be allowable, the depreciation schedule must:

- Include each asset in use with adequate description of the asset;
- Include the historical cost and accumulated depreciation;
- Include the assets' dates of acquisition;

- Indicate useful life and depreciation method;
- Reconcile to the provider's trial balance; and
- Correspond to the cost report period.

If the provider uses an accelerated depreciation method for book purposes, the provider must prepare and submit a straight-line depreciation schedule for the cost reporting period.

So long as an asset is being used, its useful life is considered not to have ended, and consequently the asset is subject to depreciation based on a revised estimate of the asset's useful life as determined by the provider and approved by LDH.

For example, if a fifty-year old building is used at the time the provider enters the program, depreciation is allowable on the building even though it has been fully depreciated on the provider's books. Assuming that a reasonable estimate of the asset's continued life is twenty years, (seventy years from the date of acquisition) the provider may claim depreciation over the next twenty years if the asset is in use that long.

Valuation of In-Kind Contributions

In-kind contributions represent the value of non-cost contributions related to the direct care of recipients provided by private organizations and individuals. In-kind contributions may consist of charges for real property and equipment and value of goods and services directly benefiting and specifically identifiable to all recipients in the approved program.

Specific procedures for the facilities in placing a value on in-kind contributions from private organizations and individuals are set forth below:

Valuation of Volunteer Services

Volunteer services may be counted as a program cost only if the requirements of the HIM-15, Part I, Chapter 7 are met. In order to qualify under this chapter, volunteers must work more than 20 hours per week in various types of full-time positions that are normally occupied by paid personnel of providers not operated by or related to religious orders. Services must be related directly to recipient care or in administrative positions essential to the provision of that care.

Volunteers must be members of an organization of non-paid workers that has arrangements with the provider for the performance of services by volunteer workers without direct remuneration to the volunteer by either organization.

Value for volunteers cannot exceed the amounts for regular working hours (excluding overtime) of paid employees who perform similar services. If there are no similar positions within the organization, the valuation cannot exceed the amount paid for such services by other providers in the area of similar size, scope of services, and utilization.

Normal fringe benefits can be included in the valuation, but social security taxes, workmen's compensation, State unemployment insurance and any other costs stemming from legislative requirement cannot be included.

Valuation of Donated Equipment, Buildings, and Land, or Use of Space

The value of donated property will be determined as follows:

- Equipment and buildings:

  The value of donated equipment or buildings should be based on the donor's cost less depreciation or the current market prices of similar property, whichever is less. The current market price should be established by a recognized appraisal expert. The title of the donated equipment and building must be legally in the name of the facility.

- Land or use of space:

  The value of donated land should be based on the donor's cost or the current market price of similar property. The current market prices should be established by a recognized appraisal expert. Use of space will not be considered in determining allowable cost with one exception. The exception is if the provider and the donor organization are both part of a larger organizational entity, such as units of a state or parish government, the cost related to the donated space is included in the allowable cost of the provider.

Valuation of Other Costs

Other necessary costs incurred specifically for an indirect benefit to the program on behalf of all recipients may be accepted as program costs provided they are adequately supported and permissible under the approved program. Such costs must be reasonable and properly documented.

Consultants, such as pharmacy consultants, not qualifying under the provisions for valuation of volunteer services, will qualify for valuation under this section, provided the service is an integral and necessary part of an approved program.

The following requirements pertain to the facility's supporting records for in-kind contributions from private organizations and individuals:

- The extent of volunteer services must be supported by the same methods used by the facilities for its employees.

- The basis for determining the costs for personal services, equipment, and buildings must be documented.

AUDITS AND DESK REVIEWS

Audits

Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IIDs) shall be subject to financial and compliance audits. Each ICF/IID shall file an annual facility cost report, central office cost report, related habilitation cost report, and a cost report indicating the cost for services provided to each resident eligible for an extraordinary rate.

All providers will be subject to an audit of their books and records from time to time by state or federal regulators or contractual auditors of the Louisiana Department of Health (LDH) Audit selection shall be at the discretion of LDH. The audit will be designed to gain assurances including, but not limited to, the following:

- Monies paid to the provider by LDH for services to recipients are properly used for the purpose intended as reflected in the cost reports submitted by the provider;
- Non-allowable costs are removed for cost reporting purposes;
- Costs are properly reflected on reports to LDH, and that significant misclassifications have not occurred; and
- Reported occupancy is accurate.

Whenever possible, the records necessary to verify information submitted to LDH on Medicaid cost reports, including related-party transactions and other business activities engaged in by the provider, must be accessible to LDH audit staff in the state of Louisiana.

Facility Cooperation

The ICF/IID shall cooperate with the audit process by:

- Promptly providing all documents needed for review;
- Providing adequate space for uninterrupted review of records;
- Making persons responsible for facility records and cost report preparation available during the audit;
- Arranging for all pertinent personnel to attend the exit conference;

- Insuring that complete information is maintained in recipient's records; and
- Correcting areas of noncompliance with state and federal regulations **immediately** after the exit conference time limit of 15 days.

Cost of Out-of-State Audits

When records are not available to LDH audit staff within Louisiana, the provider must pay the actual costs for LDH staff to travel and review the records out-of-state.

If a provider fails to reimburse LDH for these costs within 60 days of the request for payment, LDH may place a hold on the vendor payments until the costs are paid in full.

Desk Reviews

In addition to the exclusions and adjustments made during desk reviews and on-site audits, LDH 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.

Providers will be subject to a desk review annually. Field audits will be conducted for a reasonable number of providers each year.

Records Retention

The facility shall retain such records or files as required by LDH 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.

If LDH's auditors determine that a facility's records are unauditable, the vendor payments may be withheld until the facility submits an acceptable plan of correction to reconstruct the records. Any additional costs incurred to complete the audit shall be paid by the provider.

Errors

If LDH's audit of the residents personal funds account indicates a material number of transactions were not sufficiently supported or material noncompliance, then LDH shall initiate a full scope audit of the account. The cost of the full scope audit shall be withheld from the vendor payments.

Exclusions from Database

Providers with disclaimed audits and cost reports for other than a 12-month period will be excluded from the database used to calculate the rates.

SANCTIONS AND APPEALS

Sanctions

Providers should refer to Chapter 1 – General Information and Administration of the *Medicaid Services Manual* or and in the Louisiana Administrative Code, LAC 50: VII, Chapters 321 and 323 for additional information on sanctions and appeals.

When Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IID) does not comply with the requirements set forth in the ICF/IID **Standards for Payment**, the Louisiana Department of Health (LDH) may impose sanctions. Sanctions may involve the following:

- Special staffing requirements;
- Withholding of vendor payments;
- Civil fines;
- Denial of payments for new admissions; or
- Termination of the ICF/IID's certification as a Medicaid provider.

Special Staffing Requirements

When the secretary of LDH determines that additional staffing or staff with specific qualifications would be beneficial in correcting deficient practices, LDH may require a facility to hire additional staff on a full-time or consultant basis until the deficient practices have been corrected. This provision may be invoked in concert with, **or** instead of, the sanctions cited below.

Withholding of Vendor Payments

LDH may withhold vendor payments in whole or in part in the following situations, which are not all inclusive:

- **Delinquent Staffing Report** – when the ICF/IID provider fails to timely submit a required, completed staffing report. After LDH notifies the provider of the

delinquent report, vendor payments may be withheld until the completed report is received.

- **Unapproved Staffing Shortage** – when a report indicates an unapproved staffing shortage, vendor payments may be withheld until staffing is brought into compliance.

- **Incorrect/Inappropriate Charges** – when LDH determines that the ICF/IID incorrectly or inappropriately charged recipients, families, or responsible parties, or there has been misapplication of recipient funds, vendor payments may be withheld until the facility does the following:

    - Makes restitution; and
    - Submits documentation of such restitution to LDH Bureau of Health Services Financing.

- **Delinquent Cost Report** – when an ICF/IID fails to submit a cost report within 90 days from the fiscal year end closing date, a penalty of 5 percent of the total monthly payment for the first month and a progressive penalty of 5 percent of the total monthly payment for each succeeding month may be levied and withheld from the vendor's payment for each month that the cost report is due, not extended, and not received. The penalty is nonrefundable.

  Note: BHSF may grant a 30-day extension of the 90-day time limit, when requested by the ICF/IID provider, if just cause has been established. Extensions beyond 30 days may be approved for situations beyond the ICF/IID's control.

- **Cost Report Errors** – errors greater than 10 percent in the aggregate for the ICF/IID provider for the cost report year may result in a maximum penalty of 10 percent of the current per diem rate for each month the cost report errors are not corrected. The penalty is non-refundable.

- **Corrective Action for Audit Findings** – vendor payments may be withheld when a facility fails to submit corrective action in response to financial and compliance audit findings within **15 days** after receiving the notification letter until such time compliance is achieved.

- **Failure to Respond or Adequately Respond to Requests for Financial/Statistical Information** – failure of a facility to respond or adequately respond to requests from LDH for financial and statistical information within 15 days after receiving the notification letter may result in payments being withheld until the requested information is received.

- **Insufficient Medical Recertification** – when a facility fails to secure recertification of a recipient's need for care and services, the vendor's payment for that individual may be withheld or recouped until compliance is achieved.

- **Inadequate Review/Revision of Plan of Care (IHP)** – when a facility repeatedly fails to ensure that an adequate IHP for a recipient is reviewed and revised at least at the required intervals, payment may be withheld or recouped until compliance is achieved.

- **Failure to Submit Response to Survey Reports** – when a facility fails to submit an acceptable response within 30 days after receiving a survey report from LDH, CMS, OIG or the Legislative Auditor, vendor payments may be withheld until an adequate response is received, unless the appropriate agency extends the time limit.

  Corrective Action on Complaints – when a facility fails to submit an adequate corrective action plan in response to a complaint within seven days after receiving the complaint report, vendor payments may be withheld until an adequate corrective action plan is received, unless the time limit is extended by LDH
  .

- **Delinquent Utilization Data Requests** – facilities will be required to submit utilization data in a timely manner when requested by LDH. Providers will be given written notice when the utilization data has not been received by the due date. The notice will advise the provider of the date by which the utilization data must be received to avoid withholding of vendor payments. The due date will never be less than 10 days from the date the notice is mailed to the provider. If the utilization data is not received by the due date indicated in the notice, payments will be withheld until the utilization data is received.

- **Termination or Withdrawal from the Medicaid Program** – when a provider is terminated or withdraws from the Medicaid Program, vendor payments will be withheld until all programmatic and financial issues are resolved.

GLOSSARY OF TERMS

American Association on Intellectual and Developmental Disabilities (AAIDD) - an association that promotes progressive policies, sound research, effective practices, and universal human rights for people with intellectual and developmental disabilities. AAIDD was formerly called the American Association on Mental Retardation.

Abuse – is the infliction of physical or mental injury to an individual or causing an individual's deterioration to such an extent that his/her health, moral or emotional well-being is endangered. Examples include, but are not limited to: sexual abuse, exploitation or extortion of funds or other things of value.

Active Treatment – an aggressive and consistent program of specialized and generic training, treatment, health and related services directed toward the acquisition of behaviors necessary for the individual to function with as much self-determination and independence as possible and the prevention and deceleration of regression or loss of current optimal functional status.

Acuity Factor – an adjustment factor which will modify the direct care portion of the Inventory for Client and Agency Planning (ICAP) rate based on the ICAP level for each resident.

Adaptive Behavior – the effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected for his age and cultural group. Since these exceptions vary for different age groups, deficits in adaptive behavior will vary at different ages.

Agency – see Medicaid Agency

Ambulatory – the ability to walk.

ANSI – American National Standards Institute

Applicant – an individual whose written application for Medicaid has been submitted to the Agency but whose eligibility has not yet been determined.

ART—Accredited Record Technician

Attending Physician – a physician, currently licensed by the Louisiana State Board of Medical Examiners, designated by the individual, family, agency, or responsible party as responsible for the direction of overall medical care of the individual.

Autism – a condition characterized by disturbance in the rate of appearance and sequencing of developmental milestones: abnormal responses to sensations, delayed or absent speech and language skills while specific thinking capabilities may be present and abnormal ways of relating to people and things.

Bureau of Health Services Financing (BHSF) – The program within DHH, approved under Title XIX of the Social Security Act, responsible for the administration of the state's Medical Assistance Program (Medicaid).

Capacity for Independent Living –the ability to maintain a full and varied life in one's own home and community.

Cerebral Palsy –a permanently disabling condition resulting from damage to the developing brain which may occur before, during or after birth and results in loss or impairment of control over voluntary muscles.

Certification – a determination made by the Louisiana Department of Health (LDH) that an ICF/IID meets the necessary requirements to participate in Louisiana as a provider of Title XIX (Medicaid) Services.

Change in Ownership (CHOW) – any change in the legal entity responsible for the operation of an ICF/IID.

Chief Executive Officer/Facility Administrator (CEO/FA) –the individual responsible for the day-to-day administration/management of an ICF/IID.

Client –an applicant for or recipient of Title XIX (Medicaid) ICF/DD services. An individual receiving ICF/IID services may also be referred to as a participant.

Centers for Medicare and Medicaid Services (CMS) –the federal agency responsible for administering the Medicaid Program and overseeing and monitoring the state's Medicaid Program.

Code of Federal Regulations (CFR) – the regulations published by the federal government. **Section 42** includes regulations for ICFs/DD.

Comprehensive Functional Assessment – identifies the individual's need for services and provides specific information about the individual's ability to function in different environments, specific skills or lack of skills, and how function can be improved, either through training, environmental adaptations, or provision of adaptive, assistive, supportive, orthotic, or prosthetic equipment.

Intellectual Disabilities (ID) – as defined by the Louisiana Developmental Disability Law (Louisiana Revised Statutes 28:451.1-28:455.2) found in Appendix B.

Developmental Period – a period from birth to before a person reaches age 22.

DHHS – Department of Health and Human Services

Dual Diagnosis – when individuals are diagnosed with both a developmental disability and mental illness.

Enrollment – the process of executing a contract with a licensed and certified ICF/IID provider for participation in the Medical Assistance Program. Enrollment includes the execution of the **provider agreement** and assignment of the **provider number** used for payment.

Epilepsy – a disorder of the central nervous system, which is characterized by repeated seizures which are produced by uncontrolled electrical discharges in the brain.

Facility – an intermediate care facility for the developmentally disabled.

Fiscal Intermediary – the private fiscal agent with which LDH contracts to operate the Medicaid Management Information System (MMIS) to process the Title XIX (Medicaid) claims for services provided under the Medical Assistance Program and issue appropriate payment(s).

General Intellectual Functioning – results obtained by assessment with one or more of the individually administered general intelligence tests developed for that purpose.

HSS – Health Standards Section is the section within BHSF that is responsible for licensing certification of ICFs/IID.

ICAP Relationship – the relationship between the service level and service score for ICAP support levels is as follows:

ICAP Service Level	ICAP Service Score	ICAP Support Levels
		Pervasive Plus
1	1-19	Pervasive
2	20-29	Extensive
3	30-39	Extensive
4	40-49	Limited
5	50-59	Limited
6	60-69	Limited
7	70-79	Intermittent
8	80-89	Intermittent
9	90+	Intermittent

ICAP Service Level – ranges from 1 to 9 and indicates the service need intensity; the lower the score, the greater the need.

ICAP Service Score – indicates the level of service intensity required by an individual, considering both adaptive and maladaptive behavior.

Index Factor – based on the *Skilled Nursing Home without Capital Market Basket Index* published by Data Resources Incorporated or a comparable index if this index ceases to be published.

Individual Habilitation Plan (IHP) – the written ongoing program of services developed for each individual by an interdisciplinary team in order for that individual to achieve or maintain his/her potential. The plan contains specific, measurable goals, objectives and provides for data collection. It is also referred to as the Individual Plan of Care (IPC), Individual Program Plan, Individual Service Plan (ISP) or the Support Plan.

Interdisciplinary Team (IDT) – a group of individuals representing the different disciplines in the formulation of an individual's Individual Habilitation Plan. That team meets at least annually to develop and review the plans, more frequently if necessary.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – any 24-hour residential facility, whether public or private, that provides services to individuals that meet the criteria to reside in that facility. **Intelligence Quotient (IQ)** – general measure of intellectual functioning obtained by assessment with one or more of the standardized, individually administered intelligence tests. Intellectual functioning refers to general mental capacity, such as learning, reasoning, and problem solving.

Inventory for Client and Agency Planning (ICAP) – a standardized instrument for assessing adaptive and maladaptive behavior and includes an overall service score. This ICAP service score combines adaptive and maladaptive behavior scores to indicate the overall level of care, supervision or training required.

Learning – general cognitive competence of the ability to acquire new behaviors, perceptions, and information and to apply previous experiences in new situations.

Legal Status – a designation indicative of an individual's competency to manage his/her affairs.

Level of Care (LOC) – the service needs of the individual based upon his/her comprehensive functional status.

Licensed – - a written certification, whether provisional or regular, of an ICF/II's authorization to operate under state law as determined by the Louisiana Department of Health, Bureau of Health Services Financing Health Standards Section.
Licensed Certified Social Worker (LCSW) – a person holding a Master of Social Work (MSW) degree and is licensed by the Louisiana State Board of Certified Social Work Examiners.

Living Unit – a place where an individual lives including sleeping, training, dining and activity areas.

LDH - Louisiana Department of Health

LPN – Licensed Practical Nurse.

LSC – Life Safety Code.

LTC – Long-Term Care.

Major Life Activities – any one of the following activities or abilities:

- Self-care
- Understanding and Use of Language
- Learning
- Mobility
- Self-direction
- Capacity for Independent Living

Measurable Outcome – a standard or goal by which performance is measured and evaluated.

Mechanical Support – a device used to achieve proper body position or balance.

Medicaid – medical assistance provided under the State Plan approved under Title XIX of the Social Security Act.

Medicaid Agency – is the single state agency responsible for the administration of the Medical Assistance Program (Title XIX). In Louisiana, the Department of Health and Hospitals is the single state agency.

Medicaid Management Information System (MMIS) – the computerized claims processing and information retrieval system that includes all ICF/IID providers eligible for participation in the Medical Assistance Program. This system is an organized method for payment for claims for all Title XIX Services.

Medical Assistance Program (MAP) – is another name for the Medicaid Program.

Medicare – the federally administered Health Insurance program for the aged, blind and disabled under the Title XVIII of the Social Security Act.

Medicare Part A – the Hospital Insurance program authorized under Part A of Title XVIII of the Social Security Act.

Medicare Part B – the Supplementary Medical Insurance program authorized under Part B of Title XVIII of the Social Security Act.

Mental Retardation (MR) or Intellectual Disability – significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period.

> **NOTE: It must be emphasized that a finding of low I.Q. is never by itself sufficient to make the diagnosis of mental retardation/intellectual disability or in evaluating its severity. A low I.Q. shall serve only to help in making a clinical judgment regarding the individual's adaptive behavioral capacity. This judgment shall also include present functioning: including academic and vocational achievement, motor skills, social and emotional maturity, community environment typical of the individual's peers and culture, linguistic diversity and cultural differences in the way people communicate, move and behave.**

Mobility – the motor development and ability to use fine and gross motor skills; the ability to move the extremities at will.

Mobile Non-ambulatory – the inability to walk without assistance, but the ability to move from place to place with the use of a device such as a walker, crutches, wheelchair or wheeled platform.

Neglect – the failure to provide proper or necessary medical care, nutrition or other care necessary for an individual's well-being.

New Facility – an ICF/IID **newly** opened or now currently participating in the Medical Assistance Program.

Non-ambulatory – the inability to walk without assistance.

Nursing Facility or "Facility" – a health care facility such as a private home, institution, building, residence, or other place which provides maintenance, personal care, or nursing services for individuals who are unable to properly care for themselves because of illness, physical infirmity or age. These facilities serve two or more individuals who are not related by blood or marriage to the operator and may be operated for profit or nonprofit.

Office of Aging and Adult Services (OAAS) – the office within LDH that is responsible for programs serving aging adults and people with adult-onset disabilities.

Office for Citizens with Developmental Disabilities (OCDD) – the office within LDH that is responsible for programs serving people with developmental disabilities.

Operational – admission of at least one individual, completion of functional assessments(s) and development of individual program plan(s) for the individual(s); and implementation of the program plan(s) in order that the facility actually demonstrates the ability, knowledge, and competence to provide active treatment.

Provider – any individual or entity furnishing Medicaid Services under a provider agreement with the Medicaid Agency.

Qualified Mental Retardation Professional (QMRP) – a person who has specialized training and at least one year or more of experience in treating and/or working directly with and in direct contact with individuals with Mentally Retardation. To qualify as a QMRP a person must meet the requirements of **42 CFR 483.430**.

Rate Year – a one-year period corresponding to the state fiscal year from July 1 through June 30.

Rebasing – the recalculation of the per diem rate components using the latest available audited or desk reviewed cost reports.

Recipient – an individual who has been determined eligible for Medicaid; may also be referred to as a client or participant.

Registered Nurse (RN) – a nurse currently registered and licensed by the Louisiana State Board of Nursing.

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 beneficiary.

Responsible Party – a person authorized by the individual or agency to act as an official delegate or agent in dealing with the Louisiana Department of Health s and/or the ICF/IID on behalf of the recipient.

Self-care – daily activities which enable a person to meet basic life needs for food, hygiene, appearance and health.

Self-Direction – the management and control over one's social and personal life and the ability to make decisions that affect and protect one's own interests. A substantial functional limitation in self-direction would require a person to need assistance in making independent decisions concerning social and individual activities and/or in handling personal finances and/or in protecting his own self-interest.

Significant Assistance – the help needed at least one-half of the time for one activity or a need for some help in more than one-half of all activities normally required for self-care.

Significantly Sub-average – for purposes of certification for Long Term Care, an I.Q. score of below 70 on the Wechsler, Stanford-Binet, Cattell, or comparable test will be considered to establish significantly sub-average intellectual functioning.

SNF – a Skilled Nursing Facility.

Sponsor – an adult relative, friend, or guardian of the individual who has a legitimate interest or responsibility in the individual's welfare. Preferably, this person is designated on the admission forms as "responsible party."

Substantial Functional Limitation – a condition that limits a person from performing normal life activities or makes it unsafe for a person to live alone to such an extent that assistance, supervision, or presence of a second person is required more than half of the time.

Title XIX – See Medicaid.

Training and Habilitation Services – services intended to aid the intellectual, sensor motor and emotional development of an individual as part of overall plans to help the individual function at the greatest physical, intellectual, social and vocational level he/she can presently or potentially achieve.

Understanding and Use of Language – the communication involved in both verbal and nonverbal behavior enabling the individual to both understand others and to express ideas and information to others.

DEVELOPMENTAL DISABILITY LAW

A developmental disability is defined by the Developmental Disability Law (Louisiana Revised Statutes 28:451.1-28:455.2). The law states that a developmental disability means either:

A severe chronic disability of a person that:

- Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments.
- Is manifested before the person reaches age twenty-two.
- Is likely to continue indefinitely.
- Results in substantial functional limitations in three or more of the following areas of major life activity:
    - Self-care;
    - Receptive and expressive language;
    - Learning;
    - Mobility;
    - Self-direction;
    - Capacity for independent living;
    - Economic self-sufficiency;
    - Is not attributed solely to mental illness; and
    - Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

    OR

    A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine which, without services and support, has a high probability of resulting in those criteria in Subparagraph (a) of this Paragraph later in life that may be considered to be a developmental disability.

CONTACT INFORMATION

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
Bureau of Health Services Financing (BHSF) Health Standards Section	To file a complaint involving recipients of all ages in licensed health care facilities	LDH/OMF/Health Standards Section P.O. Box 3767 Baton Rouge, LA 70821 Phone: 1-877-343-5179 or (225-342-0138) Fax: (225-342-0453)
Division of Administration Law	To file an appeal request	Division of Administration Law Services P. O. Box 44033 Baton Rouge, LA 70804-4033
LDH Rate and Audit Review Section	To obtain assistance with questions on cost reports and audits	Rate and Audit Review P. O. Box 91030 Baton Rouge, La 70821 Attention: Denis Beard Phone: 225-342-3613
Molina – Provider Relations Unit	To obtain assistance with questions regarding billing information	Molina Medicaid Solutions Provider Relations Unit P. O. Box 14919 Baton Rouge, LA 70898-4919 Phone: 1-800-473-2783

OFFICE FOR CITIZENS WITH INTELLECTUAL DISABILITIES

Contact information for the central office and the regional local governing entities (LGEs) is found on the OCDD website at: http://dhh.louisiana.gov/index.cfm/page/134/n/137.

CLAIMS FILING

The link to the most recent instructions for completing the UB 04 form along with samples of UB 04 claim forms for ICF/IID routine billing are located on the home page of the Louisiana Medicaid website.

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

MEMORANDUM

DATE: July 31, 2019

TO: ICF/ID Administrators
Accountants

FROM: Enrika S. LaCour, Medicaid Program Monitor
ICF/DD Program

SUBJECT: CRYE 6/30/2019 Cost Report Preparation

This is a reminder that cost reports for CRYE 6/30/2019 are due no later than September 30, 2019.

Providers should submit the most current cost report template and the related supporting documents to Myers and Stauffer electronically or by other electronic means (cd, etc.). The template for cost reports can be found at https://www.mslc.com/Louisiana/CaseMix.aspx Please refer to the "Instructions" and "Cover" tabs in the cost report file if you have questions on how to complete the cost report. Pay special attention as to how to name your cost report file so that your cost report can be readily identified.

The table below indicates the salary limits for rate setting purposes for the facility administrators and assistant administrators.

Salary Limitations	**1-100 beds**	**101-200 beds**	**201-300 beds**	**300+ beds**
Administrator	$105,206.00	112,570.00	$120,453.00	$137,904.00
Assistant Administrator	$85,883.00	$98,322.00	$105,206.00	$112,750.00

Upon electronic submission of your cost report to Meyers and Stauffer, you will get two emails. One email will state the cost report has been received. Until you receive the second email that states your cost report is complete, it will be considered as late. It is the provider's responsibility to follow up with Meyers and Stauffer and ensure their cost report is complete. Without a **completed** cost report on file, you will incur non-refundable penalties.

Extensions will only be granted under extenuating circumstances and the rule will be followed. Written requests must be received prior to the due date before a 30-day extension is granted. There will be only one extension granted. The request should explain in detail why the extension is necessary. **Internal company audits are not an acceptable reason for an extension.** Please adjust your internal audit schedules to meet the requirements of cost report submission, as non-refundable penalties will be applied in accordance with the rule. Requests for cost report extensions should be emailed to enrika.lacour@la.gov prior to the deadline September 30, 2019. Requests submitted after this date will be out of compliance, not approved and non-refundable penalties will apply.

For those facilities receiving additional add on rates for complex care, pervasive plus and medical supplies, please be aware that there is a direct care floor you must meet to avoid any recoupments.

If you were a CEA that transitioned out of the transitional rate, a special cost report template will need to be sent to you. Please notify me via email if you need that special template.

If you have any questions, you can contact me at 318-487-5006 or enrika.lacour@la.gov .

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

April 17, 2018

To: ICF/IID Administrators

From: Lana Ryland

Re: Civil Service Salary Limits

Effective January 2, 2018, the Civil Service Limits were increased as follows:

MR/DD Regional Administrator 1 (1-100 beds)	$105,206
MR/DD Regional Administrator 2 (101-200 beds)	$112,570
MR/DD Regional Administrator 3 (201-300 beds)	$120,453
MR/DD Regional Administrator 4 (over 300 beds)	$137,904
MR/DD Regional Assoc. Administrator 1 (1-100beds)	$ 85,883
MR/DD Regional Assoc. Administrator 2 (101-200 beds)	$ 98,322
MR/DD Regional Assoc. Administrator 3 (201-300 beds)	$105,206
MR/DD Regional Assoc. Administrator 4 (over 300 beds)	$112,750

Bienville Building • 628 N. Fourth St. • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Phone: (225) 342-0127 • Fax: (225) 342-9462 • www.dhh.la.gov

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

MEMORANDUM

DATE: May 20, 2015

TO: All Private ICF/DD Providers

FROM: Randy Davidson, Program Manager 3

SUBJECT: **Clients' Personal Funds Account Policy Clarifications**

A review of recent reports issued by Postlethwaite & Netterville indicates several issues of non-compliance with the ICF/DD Standards for Payment and Provider Manual by ICF/DD providers. The purpose of this letter is to provide clarification of DHH policies on these issues:

1) **The specific purpose of the disbursement was not recorded on the client's ledger:** The ICF/DD Provider Manual, Section 26.7, Record Keeping requires that a file be maintained for each participating client. Each file or record shall contain all transactions pertinent to the account, including the following information for withdrawals: amount, date, check/petty cash voucher number, payee (if check is issued), and purpose of withdrawal. DHH expects the provider to record the **specific** purpose of the disbursement on the clients' ledgers. Purposes such as "client spending" or "spend down" are not considered to be specific purposes.
2) **Checks were made payable to clients in amounts exceeding $100:** The ICF/DD Provider Manual, Section 26.7, Record Keeping requires that the ICF/DD ensure the soundness and accuracy of the recipient fund account system. DHH does not consider it to be a sound business practice for checks in large amounts to be written to clients. DHH requires checks for large purchases (amounts over $100) to be made payable to specific vendors.
3) **Checks were made payable to cash or employees of the facility:** The ICF/DD Provider Manual, Section 26.7, Record Keeping requires that checks shall not be payable to "cash" or employees of the facility.
4) **Clients maintained balances greater than $2,000 at the beginning of certain months:** Louisiana Register, Vol. 31, No.09, September 20, 2005, Title 50, Part VII. Subpart 3. Intermediate Care Facilities for the Mentally Retarded, Chapter 331, Vendor Payments, Section 33103. Payment Limitations, A. requires that the facility refund all Medicaid payments made on behalf of ineligible clients.
5) **Receipts were not provided for check disbursements:** The ICF/DD Provider Manual, Section 26.7, Record Keeping requires that supporting documentation be maintained for each withdrawal as follows: cash register receipt with cancelled check or petty cash voucher signed by the client; or invoices with cancelled check or petty cash voucher signed by the client; or petty cash voucher signed by the client; or cancelled check.

6) **Providers did not maintain a clients' personal funds account petty cash fund:** The ICF/DD Provider Manual, Section 26.7, Record Keeping requires that the provider have a minimum of cash on hand to meet clients' spending needs. Cash on hand shall be maintained on an imprest petty cash system that includes pre-numbered petty cash vouchers. Petty cash shall be maintained at the facility and shall be available to the recipients 24 hours a day, 7 days a week. DHH requires providers to use the petty cash fund for client disbursements of $50 or less.

Failure to implement and/or adhere to the above clarified policies are in direct violation of the Louisiana Register, Vol 31, No. 09, September 20, 2005, Title 50, Part VII. Subpart 3. Intermediate Care Facilities for the Mentally Retarded, Chapter 307, Records, Subchapter A, Client Records, §, Section 33103. Payment Limitations, §30709, Financial Records, and place the facility at risk for fines, penalties and/or sanctions as allowed by the provider enrollment agreement.

Please call Lana Ryland, Program Manager at 225-342-9488 or lana.ryland@la.gov for any questions related to the above clarifications.

RD/lr

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

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

MEMORANDUM

TO: All Nursing Facility and ICF-MR Providers

FROM: Jerry Phillips
Medicaid Director

SUBJECT: New Procedures for Optional State Supplement Checks

DATE: August 6, 2007

Effective September 1, 2007, the Department of Health and Hospitals (DHH) will assume the responsibility of issuing Optional State Supplement (OSS) checks to eligible residents of nursing facilities and intermediate care facilities. The monthly OSS checks are issued to residents who receive SSI benefits and who meet the criteria for supplemental payments.

The Department of Social Services previously handled these supplemental payments by sending paper checks to the facility or the resident's responsible representative. DHH will now issue payments to the facilities via electronic funds transfer (EFT). The funds will be transferred the first full work week of each month. **This transaction will occur prior to the monthly Long Term Care check-write.** Attached is the OSS schedule for the year. Since this entire process will be done electronically, please verify that your EFT information as correct. If you have any questions regarding EFT, please contact Provider Enrollment at 225-216-6370.

Since these funds are designated for the personal care needs of the resident, you must transfer the funds to the resident's personal funds account **within three business days of receipt** of the EFT. There will be a monthly remittance advice statement available on www.lamedicaid.com for the facility to download. Once you log into the secure provider area on the Provider Applications page, click the link called OSS Checks and click on Remittance Advice Statements. All return payments will be handled electronically through the OSS Checks link. A user manual for the OSS process will be available on this same link. If you need assistance with the secure provider area, contact the Technical Support Help Desk at 1-877-598-8753.

If you have any questions or need additional information regarding these new procedures, please contact Laurie Tichenor at 225-342-9076.

JP/SV/khb

Attachment

Bobby Jindal
GOVERNOR

Anthony Keck
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

August 18, 2010

To: Private ICF/DD Facilities
From: Randy Davidson RD

Re: Clients' Funds Account Concern

Postlethwaite & Netterville recently brought to our attention a developing trend among ICF/DD facilities to eliminate the clients' petty cash fund. Rather than maintain a petty cash fund for minor client purchases, providers are writing clients' funds checks out to the clients. Some of these check amounts are quite substantial.

Providers should bear in mind that writing checks out to the clients with no documentation as to how the money was spent is considered a substantial finding in an audit. Providers who cannot account for clients' funds disbursements will be expected to refund such amounts to the client.

Our interpretation of the Standards for Payment regarding clients' funds disbursements is as follows:

- Providers are required to maintain a petty cash fund. The petty cash fund should be used for minor purchases and small amounts of spending money (i.e. less than $50 per client). Vouchers signed by the client or two witnesses should be maintained for all petty cash disbursements.
- The clients' funds checking (or savings) account(s) should be used for more significant purchases / disbursements. A cancelled check and receipt / invoice should support all check transactions. Savings account withdrawals should be supported by a withdrawal slip and a receipt / invoice.
- Canceled checks written to family members or responsible parties are sufficient receipts for disbursements if coupled with information regarding the purpose of the expenditure.

It is the policy of the Department of Health and Hospitals that the disbursement of clients' funds be supported by appropriate documentation.

If you have questions, please call Mary Norris at 225-342-2768, Cheryl Washington at 225-342-6222 or Enrika Buggage at 225-342-1999.

PROVIDER REIMBURSEMENT MANUAL
PART I

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