**Iowa Department of Human Services**
**Supplemental Schedule D-4 Instructions**

The purpose of HCBS Supplemental Schedule D-4, "Daily Rate Worksheet," is to calculate the unit daily rate cost per living site. Costs reported by site should be consistent with those reported on Schedule D, less any adjustment for the limit on indirect administrative costs. The Schedule D-4 consists of two parts:

1. Site Daily Rate Worksheet
    a. Sum total of the Individual Daily Rate Worksheets which calculates the average daily rate for the ID, RBSCL, or BI site
    b. Separate Site Daily Rate Worksheets must be submitted for an ID, RBSCL, and/or BI site
    c. Completed and submitted by the provider
2. Individual Daily Rate Worksheet
    a. Completed for each member living at the site
    b. Completed by the interdisciplinary team including the case manager and the provider
    c. Submitted by the provider

Submit a Schedule D-4 for the site rate(s) (Site Daily Rate Worksheet) along with separate schedules for each member (Individual Daily Rate Worksheet). The Individual Daily Rate Worksheets must be submitted for each member even if all members share the same rate at the site.

Supplemental Schedule D-4 should be completed for the following reasons:

1. To establish a daily rate for a New Site.
2. To change a daily rate due to significant changes in the cost per unit for a member due to
    a. change in member service needs
    b. change in members at the site.

A "significant" change occurs when a member's functioning level changes or a vacancy in unable to be filled within 30 days.

A supplemental Schedule D-4 may be submitted no more than once every three (3) months for the above reasons. The projected rate established will **not** be inflated by the consumer price index (CPI).

**No rate changes should be authorized in ISIS until review of the rate (D-4) and/or service plan are approved.**

**Site Daily Rate Worksheet**

There are two pages to the Site Daily Rate Worksheet. Site Page 1 will list all members living at the site, **regardless of funding.** Site Page 2 will consolidate expenses for each site rate needed. If the site serves members on different waiver types (ID, BI, etc.), the provider will submit more than one Site Page 2.

**Page 1**
**Effective Date:** Effective date requested for the rates

**Provider Name:** Agency name

**NPI:** 10 digit NPI Number

**Site Rate / Individual Rate:** Check box to indicate if rate(s) requested is a Site or Individual Rate(s).

**New Site:** Check box if the Schedule D-4 is being submitted to establish a daily rate for new site.

**Existing Site Change:** Check box if the Schedule D-4 is being submitted to change an existing site rate.

**Site Name:** If the Schedule D-4 is being submitted to change an existing site rate, include the Site Name of the site being changed (e.g. SCL-A(1), SCL-BI A(1), RBSCL-A(1)).

**Site Address:** Enter the street address of the site.

**Site City:** Enter the city of the site.

**Explanation of Changes:** If the Schedule D-4 is being submitted to change an existing site rate, include an explanation of the significant changes in the living site situation.

**Iowa Department of Human Services**
**Supplemental Schedule D-4 Instructions**

**List all Members living at the site:** Each member living at the site, **regardless of funding**, will be included in the table. The table should include each member ID, member name, and case manager name. The table should also include if the member is funded by Money Follows the Person (MFP), a Managed Care Organization (MCO), and the Waiver Type related to the services provided to each member.
Waiver Type categories of pay are ID, BI, RBSCL, Hab, County, or Private Pay.

**Page 2 - More than one Site Page 2 worksheet will be submitted if the site has members for multiple waiver types (ID, BI, etc.)**

**Effective Date:** Effective date requested for the rates

**Provider Name:** Agency name

**NPI:** 10 digit NPI Number

**Site Name:** If the Schedule D-4 is being submitted to change an existing site rate, include the Site Name of the site being changed (e.g. SCL-A(1), SCL-BI A(1), RBSCL-A(1)).

**Waiver Type:** Enter waiver type (ID, BI, RBSCL) for the site rate being submitted. Ensure only expenses and units for the appropriate waiver type are entered.

**Consolidated Site Expenses, Units and Unit Cost for all Members (for specific waiver type):** Sum the amounts on the Individual Daily Rate Worksheets, by line item for the specific waiver type. Show the lower of actual indirect costs or the 20% limit and add it to total direct costs. Divide total costs by the units of service provided to calculate a unit cost. Each separate Site Daily Rate Worksheet will only include expenses and units for that specific waiver type.

**Certification:** The Officer or Administrator of the Agency will sign and date the Site Daily Rate worksheet to certify that the schedule is true and correct. It will also certify that the schedules were prepared in accordance with instructions and that only allowable costs necessary to provide the care are included in the site rate.

**Individual Daily Rate Worksheet**

The provider and case manager will work together to submit the Individual Daily Rate Worksheet. An Individual Daily Rate Worksheet will be completed for all members living at the site, **regardless of funding**.

**Effective Date:** Effective date requested for the rates

**Provider Name:** Agency name

**NPI:** 10 digit NPI Number

**Site Name:** If the Schedule D-4 is being submitted to change an existing site rate, include the Site Name of the site being changed (e.g. SCL-A(1), SCL-BI A(1), RBSCL-A(1)).

**Member Name:** Name of member

**Member ID:** Medicaid ID number of member

**Case Manager:** Name of case manager responsible for member service plan

**Indicate if Member had a change in service plan (Y/N):** Complete a separate Individual Daily Rate worksheet for every member living in the site. Answer yes for each member where a change in service plan occurred to necessitate the rate change.

**Provide explanation of the change:** If the member had a change in service plan which has resulted in a change in rate, include an explanation of the service plan changes and how the changes affected the individual rate.

**Line 2120 - Professional Direct Staff**: Enter salary expense of professional direct staff hours related to the specific needs of the member. Also include the number of direct hours associated with the salary. This does not

include administrative time. Administrative time is spent on general management of program operations and is not a direct cost. Professional direct staff provide assistance and support to direct support staff, may provide some direct service to the member in the absence of direct support staff, and may supervise some direct support staff activities. Examples of positions include program directors, program supervisors, team leaders, and coordinators.

**Line 2130 - Other Direct Staff**: Enter salary expense of other direct staff hours related to the specific needs of the member. Also include the number of direct hours associated with the salary. Other direct staff provide direct support and assistance to the member. The number of direct support hours corresponding to direct wages should be supported by the staff ratios and services listed in the Individual Service Plan. Direct support wages must reflect all direct support hours provided by agency personnel on behalf of the member.

**Line 2140 - Other Direct Care Training:** Enter salary expense of other direct staff hours related to other direct care staff training. Also include the number of training hours associated with the salary. Expense reported on line 2140 may only be reported for direct care staff whose primary function is to provide direct care to members or support and/or supervise direct care workers (line 2120 or 2130 staff). Documentation such as, but not limited to, continuing education certificates, training invoices, and payroll reports must be maintained to support the expense incurred. In addition, all training expense incurred must serve the purpose of enriching direct care worker skill sets to improve the quality of direct care services provided to HCBS members.

**Line 2200 – Direct Staff Benefits:** Enter benefit expense associated with the employees included on Lines 2120 and 2130.

**Line 2300 – Direct Staff Payroll Taxes**: Enter payroll tax expense associated with the employees included on Lines 2120 and 2130.

**Line 3210 - Mileage and Auto Rental**: Enter staff mileage expense, lease payments, or short-term rental expense for transportation when member is not in the vehicle. For mileage reimbursement for business use of an employee's personal vehicle, enter the estimated number of miles and the rate paid per mile corresponding to the expense. Mileage reimbursement is limited to $0.39 per mile. Expense should be specific to the service being provided and be related to the waiver program. Provide explanation of expense and estimates used (mileage).

**Line 3250 - Agency Vehicles Expense**: Enter expense for operation and maintenance of agency-owned vehicles for transportation when member is not in the vehicle. The estimate can be calculated by multiplying number of miles by a rate per mile. Miles and the rate per mile must be entered on the Schedule D-4. The expense can also be estimated based on actual yearly cost of the agency vehicle. If based on actual cost, include a description of the vehicle expenses (e.g. maintenance, insurance, registration, parking expense, etc.) Expense should be specific to the service being provided and be related to the waiver program.

**Line 3290 - Other Related Transportation**: Include expense attributable to the actual transporting of the member (provided by staff, taxi, car pool, or bus fare) to allow member access to community resources and opportunities. Needs must be identified in the member service plan. This item is subject to the $1,570 limit on member needs items.

**Line 3330 - Direct Care Development and Training:** Include expense related to direct care staff training supplies and course fees. This line may be used to report training registration fees, training workbooks and supplies, and certification fees. Report transportation to and from trainings on line 3210. Expense reported on this line must relate directly to the enrichment of direct care worker skill sets and support a goal of providing improved quality of care to HCBS members. Documentation such as, but not limited to, supplies invoices and continuing education certificates must be maintained to support expense reported on Line 3330.

**Line 3520 – Other:** Include consultation expenses (such as an interpreter) and expenses directly related to the implementation of specific goals identified in the member's service plan. Needs must be identified in the member identified in the member service plan. These can include behavior programming and training, reinforcement for behavior modification, and/or socialization. This item is subject to the $1,570 limit on member needs items.

**Line 4320 – Other Equipment Repair and Purchase:** Include expense amounts for the modification or repair of the member's living unit based on specific member needs. Expenses included may provide for reasonable accommodation of the behaviors of the member in rental units. For member-owned units, minor maintenance expenses may be included. Also, include household furnishings needed by the member. If the member needs

furniture and does not have any or cannot access any through other resources, that expense can be included here. Any property expenses related to providing room and board are not reimbursable. Needs must be identified in the member service plan. This item is subject to the $1,570 limit on member needs items.

**Lines 3290, 3520 and 4320** are for member specific support expenses needed for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the inter-disciplinary team for each member. The assessed specific support expense needs must be specifically identified in the Medicaid case manager's service plan. The total costs of all three lines shall not exceed $1,570 per member per year, and the provider must maintain records to support the expenditures.

Effective 7/1/2015, expense related to transporting members to and from medical appointments is no longer reimbursable under the HCBS program. This expense must not be included on Supplemental Schedule D-4 as part of the projected rate.

The service plan should also document the absence of member or community resources available to cover the needs and expenses. Payment should first be sought from the member; second, from other natural and community resources; and third, from the HCBS program. The agency is responsible for tracking member costs individually to ensure the cost remains within the limit. Maintain documentation to track the costs per member adequately.

The $1,570 limit on member needs items is not intended to cover the costs of staff's meals or to cover the cost of staff participation in activities, e.g. bowling, refreshments, etc. The money can be used for staff admission to activities, e.g. play, festival, when there are not member or community resources available, and there is an instructional goal for the member in the service plan.

Case Manager service plan documentation to support expenses must be specific. The use of support expenses must be an assessed need and reviewed annually by the interdisciplinary team to determine if it is a continued member need. Goals must be established for use of instructional money. The provider and case manager must maintain records of the support expenditure. Documentation in the service plan should include the need of the member, the projected expense, and the supporting calculations used to project the expense.

Examples:

- Transportation will be provided to allow Helen to access activities in her community. This will include staff mileage and bus fare. Projected costs of $800 a year for member specific transportation.
- Instructional money of up to $60 will be utilized to purchase cookbooks needed for Helen to achieve her personal outcome and goal of learning to cook nutritious meals.
- Helen will access up to $50 a month of support dollars to help pay for the costs of participating in activities in her community with friends. This is a personal outcome and goal for Helen.

**Total Direct Expense:** Sum of Line 2120 through Line 4320.

**Indirect Expense:** Indirect expense is limited to 20% of Total Direct Expense. However, provider should budget indirect expense based on historical information. If the agency indirect expense is historically below 20% of Total Direct Expense, it is not appropriate to budget 20% indirect expense without a business explanation of the increase in expense.

**Total Cost:** Sum of Total Direct Expense and Indirect Expense.

**Number of Units to be Provided:** Enter the number of daily units provided.

**Unit Cost:** Total Cost divided by Number of Units Provided.

**Staffing Schedule:** Provide an individualized staffing schedule for each member which supports the salary expense and hours included on the first page of the Individual Daily Rate Worksheet. An already developed staffing spreadsheet or document can be attached to the Individual Daily Rate Worksheet. The staffing schedule should include times of day, staff to member ratios, any other services provided to the member (e.g. day programs, work programs, member alone time), and total hours.

It is recognized that a staffing schedule of a member does change based on member needs and should be flexible to support changes for the member. The staffing schedule information is meant to be as detailed as possible from an overall schedule standpoint knowing that there will be modifications and changes. The schedule submitted should support the hours and salary expense included on the first page of the Individual Daily Rate Worksheet taking the member's needs and flexibility into consideration.

**Additional Explanations:** Provide any additional explanations for needed changes in services and/or expenses (e.g. ratios of mid management staff to members on caseload, percentage of time charged, changes in hourly wages of staff, description of staffing patterns, changes in benefit expense, changes in payroll tax expenses, etc.)

If the agency has seen an increase in expenses (e.g. benefits, taxes, average hourly wages, etc.) which has contributed to an increase in the individual rates and the site rate, including an explanation of the increased will help review of the rate calculations and support the need for an increased rate.

**Certification:** The Officer or Administrator of the Agency will sign and date each Individual Daily Rate worksheet to certify that the schedule is true and correct. The Administrator will also certify that the schedules were prepared

in accordance with instructions and that only allowable costs necessary to provide the care are included in the individual member rate.

**Iowa Department of Human Services**
**Supplemental Schedule D-4 Instructions**

The Case Manager will sign and date each applicable Individual Daily Rate worksheet to certify the staffing schedule is true and correct. The Case Manager will also certify that the schedules were prepared in accordance with instructions and that only allowable member specific costs as identified in the case plan and necessary to provide care are included in the individual member rate.

**Submission of the Site Daily Rate Worksheet and Individual Daily Rate Worksheets**

Contact Provider Cost Audit and Rate Setting at 866-863-8610, 515-256-4610 or email costaudit@dhs.state.ia.us with questions.

All completed worksheets should be sent to the Iowa Medicaid Enterprise Provider Cost Audit and Rate Setting Unit.

**Email:** costaudit@dhs.state.ia.us

**Fax:** 515-725-1353

**Mail:**
Iowa Medicaid Enterprise
Provider Cost Audit and Rate Setting Unit
P.O. Box 36450
Des Moines, IA 50315

**Iowa Department of Human Services** **SITE DAILY RATE WORKSHEET**

**HCBS SUPPLEMENTAL SCHEDULE D-4 TO FORM SS-1703-0** Effective Date: ; Date: _____

Provider Name: _____

NPI _____

Site Rate ☐ New Site ☐ Site Name _____

Individual Rates ☐ Existing Site ☐

Site Address: _____

Site City: _____

If Existing Site Change, provide explanation of changes.

_____

_____

_____

_____

_____

**List all Members living at the site including Name, Member ID, Case Manager, Service Procedure Code and indicate if the member is funded by MFP**

| Member ID | Member Name | Case Manager | MFP (Y/N) | MCO (Y/N) | Waiver Type |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Iowa Department of Human Services** **SITE DAILY RATE WORKSHEET**

**HCBS SUPPLEMENTAL SCHEDULE D-4 TO FORM SS-1703-0** Effective Date: 1/0/1900

Provider Name: _____

NPI _____

Site Name _____

Waiver Type _____

**Consolidated Site Expenses, Units, and Unit Cost for all Members included in Daily Rate**

| Form 1703-0 Line: | |
|---|---|
| 2120 - Professional Direct Staff | |
| 2130 - Other Direct Staff | |
| 2140 - Direct Care Training | |
| 2200 - Direct Staff Benefits | |
| 2300 - Direct Staff Payroll Taxes | |
| 3210 - Mileage and Auto Rental | |
| 3250 - Agency Vehicle Expenses | |
| 3290 - Other Related Transportation | |
| 3330 - Direct Care Development and Training | |
| 3520 - Other (Consultation Expenses) | |
| 4320 - Other Equipment Repair and Purchase | |
| Total Direct Expense | $ - |
| Indirect Expense (limited to 20% of direct expense) | |
| Total Cost | $ - |
| Number of Units to be Provided | |
| Unit Cost | $ - |

I certify that I have examined the accompanying schedules of expenses and the calculation of cost of service prepared for this agency and that to the best of my knowledge and belief they are true and correct. I also certify that these schedules were prepared in accordance with instructions contained in this report and the allowable cost of care excludes expenses that were not necessary to provide this care.

| SIGNED (Officer or Administrator of Agency) | Date |
|---|---|
| | |

Contact Provider Cost Audit and Rate Setting at 866-863-8610, 515-256-4610 or email costaudit@dhs.state.ia.us with questions. All completed worksheets should be sent to the Iowa Medicaid Enterprise at the following e-mail address: costaudit@dhs.state.ia.us, fax 515-725-1353 or mail to: Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, IA 50315.

**Iowa Department of Human Services**

**HCBS SUPPLEMENTAL SCHEDULE D-4** **INDIVIDUAL DAILY RATE WORKSHEET**

**TO FORM SS-1703-0** Effective Date: 1/0/1900

Provider Name: _____ Member Name: _____

NPI _____ Member ID: _____

Site Name: _____ Case Manager: _____

Indicate if the Member had a change in service plan (Y/N) _____

Provide explanation of the change:

_____

_____

_____

_____

_____

| Form 1703-0 Line: | | | | | |
|---|---|---|---|---|---|
| 2120 - Professional Direct Staff | Direct Hours | | | | |
| 2130 - Other Direct Staff | Direct Hours | | | | |
| 2140 - Direct Care Training | Training Hours | | | | |
| 2200 - Direct Staff Benefits | | | | | |
| 2300 - Direct Staff Payroll Taxes | | | | | |
| 3210 - Mileage and Auto Rental | Number of Miles | | Rate Paid / Mile | | |
| Provide explanation of expense: | | | | | |
| 3250 - Agency Vehicle Expenses | Number of Miles | | Rate Paid / Mile | | |
| Provide explanation of expense: | | | | | |
| 3330 - Direct Care Development and Training | | | | | |
| Provide explanation of expense: | | | | | |

***Provide a description of specific expenses listed for each line. Identify other resources sought, but not available for these expenses. Expenses included on Lines 3290, 3520 and 4320 below must be included in the member's specific service plan. The sum of these lines is limited to $1,570 annually per member.**

3290 - Other Related Transportation*

Included in Member Service Plan (Y/N) _____

_____

_____

_____

3520 - Other (Consultation Expenses)*

Included in Member Service Plan (Y/N) _____

_____

_____

_____

4320 - Other Equipment Repair and Purchase*

Included in Member Service Plan (Y/N) _____

_____

_____

_____

| | |
|---|---|
| Total Direct Expense | $ - |
| Indirect Expense (limited to 20% of direct expense) | |
| Total Cost | $ - |
| Number of Units to be Provided | |
| Unit Cost | $ - |

**Iowa Department of Human Services** Member Name:

Provider Name: Site:

**Provide the staffing schedule for the member Daily Rate on the Individual Daily Rate Worksheet. This should include times of day, staff to member ratios, other services provided to the member (e.g. day/work programs), and total hours. A separate spreadsheet or document can also be attached to this form.**

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| Time Span | | | | | | | |
| Ratio | | | | | | | |
| Hours | | | | | | | |
| | | | | | | | |
| Time Span | | | | | | | |
| Ratio | | | | | | | |
| Hours | | | | | | | |
| | | | | | | | |
| Time Span | | | | | | | |
| Ratio | | | | | | | |
| Hours | | | | | | | |
| | | | | | | | |
| Time Span | | | | | | | |
| Ratio | | | | | | | |
| Hours | | | | | | | |
| | | | | | | | |
| Time Span | | | | | | | |
| Ratio | | | | | | | |
| Hours | | | | | | | |
| | | | | | | | |
| Total Hours | - | - | - | - | - | - | - |

**Provide any additional explanations for needed changes in services and/or expenses (i.e. ratio of mid management staff to members on caseload, percentage of time charged, changes in hourly wages of staff, description of staffing pattern, changes in benefit expenses, changes in payroll tax expenses, etc.)**

I certify that I have examined the accompanying schedules prepared for this member and to the best of my knowledge and belief they are true and correct. I also certify these schedules were prepared in accordance with instructions contained in this report and the allowable cost of care excludes expenses not necessary to provide this care.

| SIGNED (Officer or Administrator of Agency) | Date |
|---|---|
| | |

I certify I have examined the accompanying schedules prepared for this member. I also certify the staffing schedule and member specific expenses, as identified in the case plan, were prepared in accordance with instructions contained in this report and the member specific allowable cost of care excludes expenses not necessary to provide this care.

| SIGNED (Case Manager) | Date |
|---|---|
| | |