§32904. Temporary Reimbursement for Private Facilities

A. The department shall establish temporary Medicaid reimbursement rates of $352.08 per day per individual for a 15-bed private ICF/IID community home and $327.08 for an 8-bed private ICF/IID community home that meet the following criteria. The community home:

1. shall have a fully executed cooperative endeavor agreement (CEA) with the Office for Citizens with Developmental Disabilities for the private operation of the facility;

a. the provider shall be subject to the direct care floor as outlined in the executed CEA;

2. shall have a high concentration of people who have intellectual/developmental disabilities, significant behavioral health needs, high risk behavior, i.e. criminal-like resulting in previous interface with the judicial system, use of restraint, and elopement. These shall be people for whom no other private ICF/IID provider is able to support as confirmed by the Office for Citizens with Developmental Disabilities;

3. incurs or will incur higher existing costs not currently captured in the private ICF/IID rate methodology; and

4. shall have no more than 15 beds in one facility and 8 beds the second facility.

B. The temporary Medicaid reimbursement rate shall only be for the period of four years.

C. The temporary Medicaid reimbursement rate is all-inclusive and incorporates the following cost components:

1. direct care staffing;

2. medical/nursing staff;

3. medical supplies;

4. transportation;

5. administrative;

6. the provider fee; and

7. dental pass-through/add-on per diem rate (effective for dates of service on or after January 1, 2023).

D. The temporary 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.

E. The Medicaid daily rate will include a direct care $12 add-on to reimburse providers for increased cost related to retaining and hiring direct care staff. This add-on will be discontinued upon the next rebase, or at the discretion of the department.

NOTE: Medicaid providers have up to a year from the date of service to bill Medicaid for their claims. The provisions of this Subsection will apply to claims effective for dates of service on or after January 1, 2022.

1. Effective April 1, 2022, the minimum hourly wage floor paid to directly employed (non-contracted) non-nursing/physician direct care worker shall be $9 per hour.

a. Directly employed non-nursing/physician direct care workers will include any employee whose wage expense is reported on sch H - expenses lines A.2. - A.8. on the Medicaid cost report.

b. Providers shall submit to the department or its representatives all requested documentation to verify compliance with the direct care wage floor.

i. This documentation may include, but is not limited to, payroll records, wage and salary documents, payroll check stubs, and supplemental cost report schedules.

ii. Providers shall produce the required documentation upon request and within the time frame indicated by the department, or the provider may be subject to sanctions, full recoupment of add-on payments received, and/or disenrollment in the Medicaid Program.

c. Providers with directly employed non-nursing/physician direct care worker(s) that is (are) identified as not meeting the minimum hourly wage floor requirement shall be subject to a recoupment that is calculated as the differential between the minimum hourly wage floor and the actual hourly wage paid for all hours worked during the reporting period by the specific employee(s) that did not meet the minimum hourly wage floor requirement. This recoupment shall not exceed the total amount paid to the provider for the $12 direct care add-on in a state fiscal year. This penalty is not mutually exclusive of any other direct care floor or related penalty. Additionally, any recoupment as a result of the wage floor will not impact any other direct care floor recoupment calculation.

i. The hourly wage of a directly employed non-nursing/physician direct care worker will be calculated as the total regular (non-overtime) wage expense (exclusive of bonus, benefits, etc.) divided by the total regular (non-overtime) hours worked during the reporting period.

2. Effective April 1, 2022, a facility wide direct care floor is established at 75 percent of the per diem for direct care payment and at 100 percent of the $12 direct care add-on payment for year. In no case shall a facility receiving this 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. For facilities that also receive add-on payments related to complex care or pervasive plus, the greater of the direct care floors will be applicable.

a. If the direct care cost the facility incurred on a per diem basis, plus add-on, 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.

b. 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.

c. Direct care floor recoupment as a result of a facility not meeting the required direct care per diem floor is considered effective 30 days from the issuance of the original notice of determination. Should an informal reconsideration be requested, the recoupment will be considered effective 30 days from the issuance of the results of an informal hearing. The filing of a timely and adequate notice of an administrative appeal does not suspend or delay the imposition of a recoupment(s).

d. The direct care floor recoupment is not mutually exclusive of any penalty related to not meeting the minimum direct care wage floor or any other penalty.

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 47:593 (May 2021), amended LR 48:2129 (August 2022), LR 49:688 (April 2023).

§