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 cited during the HSS annual review or resulting from an HSS complaint investigation.

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 a safe harbor percentage of 104 percent of the total facility cost as a result of imposition of the direct care floor, except as noted in §32901.C.4.a.

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 a safe harbor percentage of 104 percent of the total facility cost as a result of imposition of the direct care floor, except as noted in §32901.C.4.a.

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.

a. For dates of service on or after July 1, 2022, if a provider receiving complex care or pervasive plus add-on payments in accordance with §32915 or §32903.H, respectively, has facility payments reduced as a result of imposition of the direct care floor, the department may, at its discretion, levy a non-refundable administrative penalty separate from any other reduction in facility payments. The administrative penalty is not subject to any facility specific safe harbor percentage specified in §32901.C, and is calculated solely on the final reduced payment amount for the cost report period in question. Under LAC 50.I.4147 of the Surveillance and Utilization Review Subsystem (SURS) Rule, the department may impose sanctions for noncompliance with Medicaid laws, regulations, rules, and policies. Facilities who have payments reduced as a result of imposition of the direct care floor that have consecutive subsequent years of reduced payments shall have the following safe harbor and administrative penalty impacts:

Consecutive Cost Report Period with Reduced Payments	Administrative Penalty Levied on Reduced Payments	Safe Harbor Percentages
1st Year	0 percent	104 percent
2nd Year	0 percent	102 percent
3rd Year	5 percent	100 percent
4th Year and Onwards	10 percent	100 percent

b. At its discretion, LDH may terminate provider participation in the complex care or pervasive plus add-on payment programs as a result of imposition of the direct care floor.

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.

a. Direct care floor recoupment and/or administrative penalty assessed 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 and/or penalty 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) and/or 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 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 by the Department of Health, Bureau of Health Services Financing, LR 44:1446 (August 2018), LR 46:28 (January 2020), LR 47:1124 (August 2021), LR 48:1581 (June 2022).

§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 25th 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.

N. Pursuant to the provisions of Act 1 of the 2020 First Extraordinary Session of the Louisiana Legislature, effective for dates of service on or after July 1, 2020, private ICF/IID facilities that downsized from over 100 beds to less than 35 beds prior to December 31, 2010 without the benefit of a cooperative endeavor agreement (CEA) or transitional rate and who incurred excessive capital costs, shall have their per diem rates (excluding provider fees) increased by a percent equal to the percent difference of per diem rates (excluding provider fees) they were paid as of June 30, 2019. See chart below with the applicable percentages:

	Intermittent	Limited	Extensive	Pervasive
1-8 beds	6.2 percent	6.2 percent	6.2 percent	6.1 percent
9-15 beds	3.2 percent	6.2 percent	6.2 percent	6.1 percent
16-32 beds	N/A	N/A	N/A	N/A
33+ beds	N/A	N/A	N/A	N/A

1. The applicable differential shall be applied anytime there is a change to the per diem rates (for example, during rebase, rate reductions, inflationary changes, or special legislative appropriations). This differential shall not extend beyond December 31, 2024.

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), amended by the Department of Health, Bureau of Health Services Financing, LR 47:370 (March 2021).

§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; and

6. the provider fee.

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).

§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 85 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 85 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), amended by the House of Representatives, House Concurrent Resolution No. 4 of the 2022 Regular Legislative Session, LR 48:2024 (July 2022).

§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 beneficiaries, when medically necessary. The add-on payment shall be a flat fee daily amount and consists of payment for one of the following components alone or in combination:

1. direct service worker add-on;

2. skilled nursing add-on; and

3. equipment add-on.

B. To qualify, beneficiaries must meet medical necessity criteria established by the Medicaid Program. Supporting medical documentation must also be submitted as specified by the Medicaid Program. The duration of approval of the add-on payment(s) is at the sole discretion of the Medicaid Program and shall not exceed one year.

C. Medical necessity of the add-on payment(s) shall be reviewed and re-determined by the Medicaid Program no less than 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 medical necessity criteria as the initial review.

D. Each add-on payment requires documentation that the enhanced supports are already being provided to the beneficiary, as specified by the Medicaid program.

E. One of the following admission requirements must be met in order to qualify for the add-on payment:

1. the beneficiary has been admitted to the facility for more than 30 days with supporting documentation of medical necessity; or

2. the beneficiary is transitioning from another similar agency with supporting documentation of medical necessity.

F. The Medicaid Program shall require compliance with all applicable laws, rules, and regulations as a condition of an ICF/IID's qualification for any complex care add-on payment(s) and may evaluate such compliance in its initial annual qualifying reviews.

G. The following additional requirements apply:

1. Beneficiaries receiving enhanced rates must be included in annual surveys to ensure continuation of supports and review of individual outcomes.

2. Fiscal analysis and reporting is required annually.

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), LR 48:2294 (September 2022).

§32917. Dedicated Program Funding Pool Payments

A. Effective for providers active and Medicaid certified as of September 1, 2019; a one-time lump sum payment will be made to intermediate care facilities for individuals with intellectual disabilities (ICFs/IID).

B. Methodology

1. Payment will be based on each provider's specific pro-rated share of an additional dedicated program funding pool totaling $4,665,635.

2. The pro-rated share for each provider will be determined utilizing the provider's percentage of total annualized program Medicaid days. Annualized program Medicaid days will be calculated utilizing the most recently desk reviewed or audited cost reports as of July 1, 2019.

3. The additional dedicated program funding pool lump sum payments shall not exceed the Medicare upper payment limit in the aggregate for the provider class.

4. The one-time payment will be made on or before June 30, 2020.

5. Payment of the one-time lump sum payment is subject to approval by the U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services (CMS).

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 46:28 (January 2020).

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).