

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 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.

a. 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).

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).