Chapter 329. Reimbursement Methodology

Subchapter A. Non-State Facilities

§32901. Cost Reports

A. Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) are required to file annual cost reports to the bureau in accordance with the following instructions.

1. Each ICF-MR 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 and 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, the pervasive plus supplement, 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 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.

4. 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).

§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. Effective for dates of service on or after October 1, 2014, non-state intermediate care facilities for persons with intellectual disabilities (ICFs/ID) 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. Non-state owned ICFs/ID 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. 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.

D. 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).

E. 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.

F. 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).

Subchapter B. Qualifying Loss Review (Private Facilities)

§32949. Basis for Administrative Review

A. The following is the qualifying loss review process for private ICF/MR facilities seeking an adjustment to their per diem rates.

B. Allowable Basis. The following matters are subject to a qualifying loss review:

1. that rate-setting methodologies or principles of reimbursement established under the reimbursement plan were incorrectly applied;

2. that incorrect data or erroneous calculations were used,

3. the facility demonstrates that the estimated reimbursement based on its prospective rate is less than 95 percent of the estimated costs to be incurred by the facility in providing Medicaid services during the period the rate is in effect in compliance with the applicable state and federal laws related to quality and safety standards.

C. Nonallowable Basis. The following matters are not subject to a qualifying loss review:

1. the methodology used to establish the per diem;

2. the use of audited and/or desk reviews to determine allowable costs;

3. the economic indicators used in the rate setting methodology;

4. rate adjustments related to changes in federal or state laws, rules or regulations(e.g., minimum wage adjustments);

5. rate adjustments related to reduction or elimination of extraordinary rates.

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 24:66 (January 1998), repromulgated LR 31:2255 (September 2005).

§32951. Request for Administrative Review

A. Any intermediate care facility for the mentally retarded (hereafter referred to as facility) seeking an adjustment to the per diem rate shall submit a written request for administrative review to the director of Institutional Reimbursements (hereafter referred to as director) in the Department of Health and Hospitals (hereafter referred to as department).

B. Time Frames

1. Requests for administrative review must be received by DHH within 30 days of either receipt of notification of rate reduction or promulgation of this rule, whichever is later. The receipt of the letter notifying the facility of its rates will be deemed to be five days from the date of the letter.

2. The department shall acknowledge receipt of the written request within 30 days after actual receipt.

3. The director shall notify the facility of his decision within a reasonable time after receipt of all necessary documentation, including additional documentation or information requested after the initial request is received. Failure to provide a decision within a reasonable time does not imply approval.

4. If the facility wishes to appeal the director=s decision, the appeal request must be received by the Bureau of Appeals within 30 days after receipt of the written decision of the director. The receipt of the decision is deemed to be five days from the date of the decision.

C. Content of the Request. The facility shall bear the burden of proof in establishing the facts and circumstances necessary to support a rate adjustment. Any costs the provider cites as a basis for relief under this provision must be calculable and auditable.

1. Basis of the Request. Any facility seeking an adjustment to the per diem rate must specify all of the following:

a. the nature of the adjustment sought;

b. the amount of the adjustment sought;

c. the reasons or factors that the facility believes justify an adjustment.

2. Financial Analysis. An analysis demonstrating the extent to which the facility is incurring or expects to incur a qualifying loss shall be provided by the facility unless the basis for review is one of the following:

a. the rate setting methodology or criteria for classifying facilities was incorrectly applied; or

b. incorrect data or erroneous calculations were used in establishment of the facility's per diem; or

c. the facility has incurred additional costs because of a catastrophe.

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 24:66 (January 1998), repromulgated LR 31:2255 (September 2005).

§32953. Basis for Rate Adjustment

A. Factors Considered. The department shall award additional reimbursement to a facility that demonstrates by substantiating evidence that:

1. the facility will incur a qualifying loss;

2. the loss will impair a facility=s ability to provide services in accordance with state and federal health and safety standards;

3. the facility has satisfactorily demonstrated that it has taken all appropriate steps to eliminate management practices resulting in unnecessary expenditures; and

4. the facility has demonstrated that its nonreimbursed costs are generated by factors generally not shared by other facilities in the facility's bed size LOC.

B. Determination to Award Relief. In determining whether to award additional reimbursement to a facility that has made the showing required, the director shall consider one or more of the factors and may take any of the actions:

1. the director shall consider whether the facility has demonstrated that its nonreimbursed costs are generated by factors generally not shared by other facilities in the facility's bed size LOC. Such factors may include, but are not limited to, extraordinary circumstances beyond the control of the facility; or

2. the director may consider, and may require the facility to provide financial data including, but not limited to, financial ratio data indicative of the facility's performance quality in particular areas of operations; or

3. the director shall consider whether the facility has taken every reasonable action to contain costs on a facility-wide basis. In making such a determination the director may require the facility to provide audited cost data or other quantitative data and information about actions that the facility has taken to contain costs.

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 24:66 (January 1998), repromulgated LR 31:2256 (September 2005).

§32955. Awarding Relief

A. The director shall make notification of the decision to award or not award relief in writing.

1. Basis of Adverse Decision

a. The director may determine that the review request is not within the scope of the purpose for qualifying loss review.

b. The director may determine that the information presented does not support the request for rate adjustment.

2. Adverse Decision Appeal. Adverse decisions may be appealed to the Office of the Secretary, Bureau of Appeals for the Department of Health and Hospitals, P.O. Box 4183, Baton Rouge, Louisiana 70821-4183 within 30 days of receipt of the decision.

3. Awarding Relief

a. Action by Director. In awarding relief under this provision, the director shall:

i. make any necessary adjustment so as to correctly apply the reimbursement methodology to the facility submitting the appeal, or to correct calculations, data errors or omissions; or

ii. increase the facility's per diem rate by an amount that can reasonably be expected to ensure continuing access to sufficient services of adequate quality for Title XIX Medicaid recipients served by the facility.

b. Scope of Decisions. Decisions by the director to recognize omitted, additional or increased costs incurred by any facility; to adjust the facility rates; or to otherwise award additional reimbursement to any facility shall not result in any change in the bed size LOC per diem for the remaining facilities in the bed size LOC, except that the department may adjust the per diem if the facilities receiving adjustment comprises over 10 percent of total utilization for that bed size LOC based on the latest audited and/or desk reviewed cost reports.

c. Effective Date. The effective date of the adjustment shall be the later of:

i. the date of occurrence of the rate change upon which the rate appeal is in response; or

ii. the effective date of this rule.

d. Limitations. The director shall not award relief to provider in excess of 95 percent of appellant facility=s cost coverage determined by inflationary trending of the year on which rates are based. The rate adjustment shall also be limited to no more than the amount of the rate for the previous rate year. Any facility awarded relief shall be audited and cost settled up to, but not over, the amount of the adjusted rate. Should a single facility that is an entity under common ownership or control with another facility or group of facilities be awarded relief, all facilities under common ownership or control with the facility awarded relief will be subject to audit and cost settlement up to, but not over, the amount of their rates.

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 24:66 (January 1998), repromulgated LR 31:2256 (September 2005).