NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing

Intermediate Care Facilities for Persons with Intellectual Disabilities
Cost Reports and Complex Care Reimbursement
(LAC 50:VII.Chapter 329)

The Department of Health, Bureau of Health Services Financing proposes to amend LAC 50:VII.Chapter 329 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health, Bureau of Health Services Financing proposes to amend the provisions governing the reimbursement methodology for intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) in order to: 1) clarify the provisions governing cost reports to align the direct care floor requirements for pervasive plus supplemental payments and complex care add-on payments with current practices; 2) require the annual renewal of the complex care add-on rate and submission of the associated documentation; and 3) eliminate the qualifying loss review requirement.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part VII. Long Term Care
Subpart 3. Intermediate Care Facilities for Persons with Intellectual Disabilities

Chapter 329. Reimbursement Methodology

Subchapter A. Non-State Facilities

§32901. Cost Reports

A. Intermediate ~~Care Facilities for the Mentally Retarded~~ care facilities for individuals with intellectual disabilities (~~ICFs-MR~~ICFs/IID) are required to file annual cost reports to the bureau in accordance with the following instructions.

1. Each ~~ICF-MR~~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.

A.2. - B.2. ...

C. Direct Care Floor

1. ...

2. For providers receiving pervasive plus supplements in accordance with §32903.H ~~and~~ 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 ~~facilities for which the direct care floor applies, if the direct care cost the facility incurred on a~~ 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 ~~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~~ 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. ~~Upon completion of desk reviews or audits,~~For facilities~~ will be notified by the bureau of any changes in amounts due based on audit or desk review adjustments~~ 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.

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:

§32915. Complex Care Reimbursements

A. Effective for dates of service on or after October 1, 2014, non-state intermediate care facilities for ~~persons~~ individuals with intellectual disabilities (~~ICFs/ID~~ICFs/IID) 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. - 7. ...

B. Non-state owned ~~ICFs/ID~~-ICFs/IID 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~~The complex ~~care criteria, the presence of a significant~~ support need screening tool shall be completed and submitted to the department annually from the date of initial approval of each add-on payment. This annual submittal shall be accompanied by all medical~~ or behavioral health need must exist and be documented. This must include:~~ documentation indicated by the screening tool form and any additional documentation requested by the department.

~~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.~~1. – 2.a.iii. Repealed.

D. ~~Enhanced Supports. Enhanced supports must be provided and verified with supporting documentation to qualify for the add-on payment. This includes~~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 ~~and~~ of at least one qualifying condition with supporting documentation ~~indicating the need for additional direct service worker resources~~; and

2. endorsement ~~and~~ of symptom severity in the appropriate category based on qualifying condition(s) with supporting documentation~~supporting documentation indicating the need for additional nursing resources; or~~.

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.

3. ~~endorsement and supporting documentation indicating the need for enhanced equipment resources (beyond basic equipment such as wheelchairs and grab bars).~~Repealed.

E. ~~One of the following admission requirements must be met in order~~ Enhanced Supports. Enhanced supports must be provided and verified with supporting documentation to qualify for the add-on payment. This includes:~~–~~

1. ~~the recipient has been admitted to the facility for more than 30 days with~~ endorsement and supporting documentation~~ of necessity and provision of enhanced supports~~

indicating the need for additional direct service worker resources; ~~or~~

2. ~~the recipient is transitioning from another similar agency with~~ endorsement and supporting documentation ~~of necessity and provision of enhanced supports.~~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).

F. ~~All~~ One of the following ~~criteria will apply for continued evaluation and payment for complex care.~~admission requirements must be met in order to qualify for the add-on payment:

1. ~~Recipients receiving enhanced rates will be included in annual surveys to ensure continuation of supports and review of individual outcomes.~~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. ~~Fiscal analysis and reporting will be required annually~~the recipient is transitioning from another similar agency with supporting documentation of necessity and provision of enhanced supports.

~~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.~~3. - 3.e. Repealed.

G. Qualification for a complex care add-on payment may be reviewed and re-determined by the department 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 standard as the initial qualifying review under this section.

H. The department may require compliance with all applicable laws, rules, and regulations as a condition of an ICF/IID's qualification for the complex care add-on rate and may evaluate such compliance in its initial and annual qualifying reviews.

I. 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), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

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.~~Repealed.

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), repealed by the Department of Health, Bureau of Health Services Financing, LR 44:

§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.~~Repealed.

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), repealed by the Department of Health, Bureau of Health Services Financing, LR 44:

§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.~~Repealed.

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), repealed by the Department of Health, Bureau of Health Services Financing, LR 44:

§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.~~Repealed.

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), repealed by the Department of Health, Bureau of Health Services Financing, LR 44:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability or autonomy as described in R.S. 49:972.

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty as described in R.S. 49:973.

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to

the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821—9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, June 28, 2018 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Rebekah E. Gee MD, MPH

Secretary