The Department of Health, Bureau of Health Services Financing amends LAC 50:VII.32904 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953.1, and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

Effective April 1, 2022, the Department of Health, Bureau of Health Services Financing amends the provisions governing temporary reimbursement for private non-state intermediate care facilities for persons with intellectual disabilities (ICFs/IID) in order to include a direct care add-on for increased cost related to retaining and hiring direct care staff and to establish a minimum hourly wage floor for direct care workers.

This action is being taken to promote the health and welfare of Medicaid recipients in ICFs/IID by ensuring continued provider participation in the Medicaid Program. It is estimated that implementation of this Emergency Rule will increase programmatic costs in the Medicaid Program by $7,004,060 for state fiscal year 2021-2022.

Effective April 1, 2022, the Department of Health, Bureau of Health Services Financing amends the provisions governing temporary reimbursement for private non-state ICFs/IID.

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
§32904. Temporary Reimbursement for Private Facilities
A. - D.4....
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:
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.

Interested persons may submit written comments to Patrick Gillies, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. Mr. Gillies is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Dr. Courtney N. Phillips
Secretary

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